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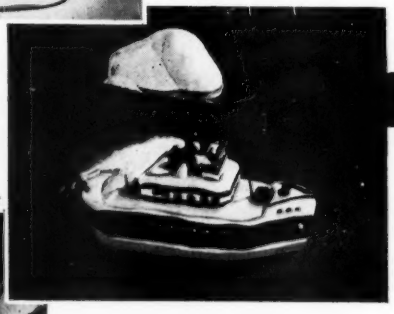

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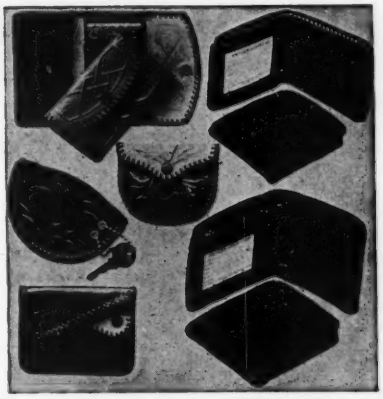

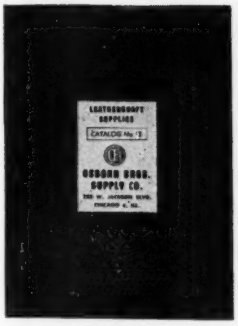

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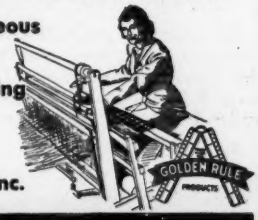

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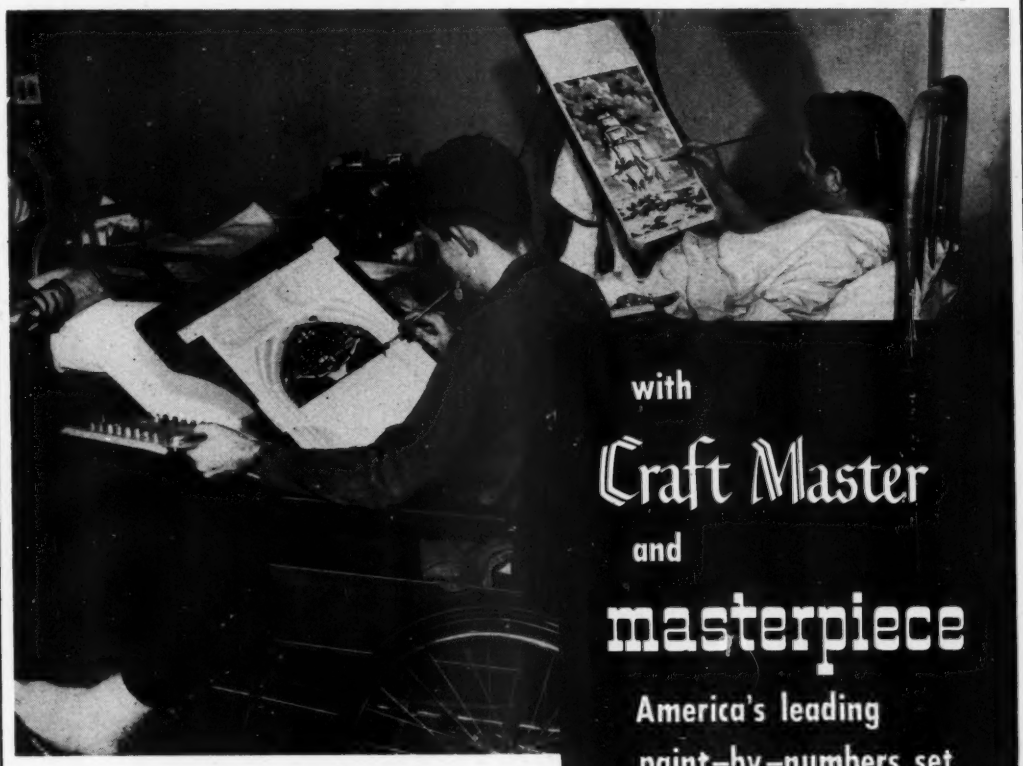

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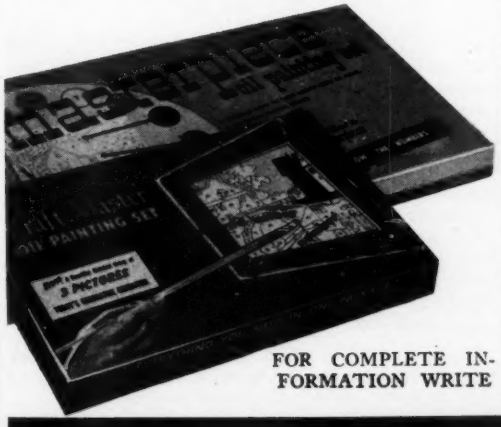

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PRE-VOCATIONAL MOTOR SKILL INVENTORY: PRELIMINARY REPORT

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INTRODUCTION

A one-hundred-item inventory of motor skills of daily occupations is under trial and development with nine children in a special class for cerebral palsied children in the public school system of Schenectady, New York. The blank form and instructions are following the pattern of a one-hundred-item inventory of activities in daily life apart from work.[6] The project is being studied by the adult vocational committee of the United Cerebral Palsy Associations, which is seeking an instrument for evaluating job potentialities of adult cerebral palsied.[26] This work is of a preliminary nature.

The pre-vocational motor skill inventory is the thirteenth of a series of inventories, checklists, examinations and evaluations which have been assembled as a guide to estimating motor status and potentialities. They are as follows:

(1) Speech evaluation[12]
(2) Range and strength inventory
(3) Elementary motor skill inventory
(4) Daily activity inventory[6]
(5) Muscle examination[14]
(6) Toilet report
(7) Clothing report (see Figure 1)
(8) Food-intake inventory
(9) Grasp and release inventory
(10) Appliances, shoes, locomotion aids, special equipment checklist
(11) Sitting, posture and chair evaluation
(12) Recreational interests list[17]
(13) Pre-vocational motor skill inventory

From these worksheets a report of motor status is made which contains a summary of the results, scores, recommendations and an exercise and activity program. This inventory method is of par-

Courtesy of Eastern New York Orthopedic Hospital-School, Inc. (Sunnyview), Schenectady, New York.

Figure 1. *The little girl* (7-G) *is wearing a stylish self-help two-piece dress, elasticized waistbaid, stretchable T-shirt with trim to match skirt; no snaps, hooks and eyes, buttons, zippers, tight neckbands, sleeves, belt, ties.*[7] *A clothing inventory, together with abilities as discovered on other inventories, has not only started a movement to improve clothing but also stimulated a sewing program among children and parents. Pre-sewing skills were included in the work-skill program with this severely disabled cerebral palsied child, the "star" of These Are Our Children, a cerebral palsy movie.*[19]

ticular value in the medical field of motor impairment which includes four main groups of conditions resulting in motor impairment: poliomyelitis, cerebral palsy, spinal cord injuries and amputations. It represents a way of organizing many pertinent details thus allowing for meaningful program-planning and appropriate recommendations. This particular system of records has as its greatest value the continual testing of one's judgment. It should be emphasized that no judgments concerning the future possibilities of any human being should remain static but rather be reviewed frequently and modified according to changes found.

Purpose. This pre-vocational motor skill inventory is for any person of any age who has one or more extremities free for work-skills. Its purpose is to obtain a motor score which, together with other data acquired, may reveal: (1) motor adequacy for training toward a specific occupation, and/or (2) the motor work potential of an employment candidate. Such a motor score would not mean that a job could be held, any more than could a man become a minister if able to stand for half an hour and talk. Intentionally excluded are the intangible elements of work associated with intelligence, personality and character such as work drives,[22,23] concept of work, initiative, responsibility, punctuality, starting and completing a task, judgment, human relations.

Need. A young man of twenty-six goes to school to learn leathercraft. The first day he has to call on a maintenance man to help him in the bathroom. If his mother did not dress him in the morning, he would have to get up at four o'clock because it takes him three hours to get himself ready. The first motor need is to take care of daily living requirements such as toilet, bathing, dressing, eating, getting around inside and outside the house and traveling.

The first day at trade school the young man finds out something else. He cannot make his hands do the measuring, ruling, cutting and pasting that even the most elementary leatherwork requires. The second motor need is to have basic motor work-skills in order to pursue an occupation.

Time is so short and the amount to be learned so great that early introduction of motor work-skills is essential. A motor work-skill program should reach down into the grades and thus permit the appraisal and development of motor work potentials early in a disabled person's life.[5,8,23] In the case of adults, guides to the motor components of work skills have long been needed. The Institute for the Crippled and Disabled in New York City has testing devices to estimate the abilities of trainees during a seventeen-day testing period which may extend to six months or more. Frederick A. Whitehouse, Ed. D., former director of education of that institute, has indicated by personal communication that guides, such as the present inventory, might be of value in shortening this testing period.

Once the activities of daily life have been learned, the work potential explored and a work-skill program laid out, attention should be placed upon work-skill training for a specific job available in the community where the disabled person is to live.

PROCEDURE

The procedure has so far entailed listing one hundred items, setting time allowances, obtaining equipment and preparing inventories of nine children.

The Inventory. The one hundred items selected have been arranged on a mimeographed worksheet similar to the daily activity record blank form,[6] the list being read from the bottom up. Individual worksheets have been used and filled out for the nine cerebral palsied children.

A choice of one hundred activities was made from a study of the following:

Jobs held by retarded adults in institutions.[1]
Jobs performed by retarded children in institutions.[1]
Positions held by cerebral palsied adults.[5]
Skills present in normal children from eighteen months to five years.[11]

Each successful field is represented by at least one item. The easiest items are grouped first on the basis of an age-level label. Aid for the age-level judgments was obtained from references as cited in the bibliography. There may be a way to key this inventory to the B'nai B'rith occupational charts.[3]

The material appearing on the mimeographed worksheet is given below to the right of the double line. To the left of the double line is information guiding the choice and arrangement of items. It should be especially noted that the "Related Work" column serves only as a means of identifying the items selected and does not indicate that the person being checked can do the work if he can perform the activity listed. For instance, in the case of item 100 at the top of the list, it is obvious that a person who can drive a car around a city block may never be a truck driver, since "Car around city block" is only one of many items making up the job responsibilities of a truck driver.

Equipment. The equipment is under trial preparatory to being definitely selected and described in detail.

The Subjects. Pre-vocational motor skill inventories were taken of nine children between the ages of eight years one month and thirteen years seven months. The children were chosen from the special ungraded public school academic class for

INFORMATION GUIDING CHOICE AND ARRANGEMENT

Age Level	*Reference*	*Related Work*
16	(15)	Truck driver
		Bookkeeper
		Draftsman
		Mason
		Appliance repair
		Electrician
		Cashier
		Butcher
	(4)	Taxi driver
		Radio repair
		Secretary
10	(1)	Sign painter
9	(1)	Shoe repair
		Shoeshine boy
9	(1)	Tailor
		House painter
		Interior painter
8	(1)	Hardware clerk
8	(1)	Laundress
8	(1)	Waitress
8	(1)	Gardener
8	(1)	Farmer
8	(1)	Gardener
8	(1)	Gardener
8	(1)	Gardener
8	(1)	Gardener
		Mechanic
8	(1)	Seamstress
8	(1)	Hair stylist
8	(1)	Barber
		Painter's helper
		Painter's helper
8	(1)	Nursemaid
8	(1)	Nursemaid
8	(1)	Baby sitter
		Dressmaker
		Typist
		Typist
8	(1)	Canner
		Cook
		Chef
		Gas station attendant
7	(1)	Packer, fancy grocery
		Newspaper boy
		Grocery store clerk
		Small store clerk
7	(1)	Factory knitter
		Gas station attendant
7	(1)	Upstairs maid
		Librarian
7	(1)	Interior painter
		Bank teller
		Carpenter
		Delivery boy
		Librarian
		Filing clerk
		Carpenter
		Carpenter
		Carpenter
7	(1)	Carpenter
7	(1)	Super-market clerk
7	(1)	Cabinet maker

MATERIAL ON BLANK FORM
*PRE-VOCATIONAL MOTOR SKILL INVENTORY**

Name *Date*

Inventory List	*Time Allowance*	*Number*
Car around city block	15 m.	100
Copying 8-column accountant's sheet	30 m.	99
Tracing simple house plan	1 hr.	98
Laying two courses common brick	30 m.	97
Plug on electric cord	15 m.	96
Replacing fuse in darkened room	15 m.	95
Pressing adding machine key ten times	15 sec.	94
Sawing 10-lb. ham	1 hr.	93
200 lbs. on brake pedal (necessary for driving)	2 sec.	92
Three tubes into radio	30 sec.	91
Touch-typing two lines	30 sec.	90
Painting STOP sign	30 m.	89
Rubber heel on shoe	20 m.	88
Giving shoe shine	20 m.	87
Cutting dress around pattern	30 m.	86
Climbing 6′ ladder against house	30 m.	85
Painting window trim	1 hr.	84
Cutting glass	30 sec.	83
Ironing, folding man's shirt	20 m.	82
Setting table for four	20 m.	81
Spading 6′x6′, 5″ deep	30 m.	80
Cultivating between two 6′ rows	1 m.	79
Raking 6′x6′	15 m.	78
Coupling garden hose to bib	1 m.	77
Rolling, storing garden hose	15 m.	76
Hoeing 6′x6′	30 m.	75
Spreading drip cloth 10′x10′	1 m.	74
Sewing dress, cut by others	1 hr.	73
Cutting man's hair	30 m.	72
Shaving man	15 m.	71
Cleaning three 1″ paint brushes	30 m.	70
Opening paint can	20 sec.	69
Bathing baby	30 m.	68
Dressing baby	30 m.	67
Feeding 6 mos. baby	30 m.	66
Threading electric sewing machine	30 sec.	65
Two sheets paper, carbon between, into typewriter	15 sec.	64
Ribbon on typewriter	20 m.	63
Blanching, peeling one lb. tomatoes	30 m.	62
Lighting gas stove	10 sec.	61
Filled 8-c. saucepan to stove	10 sec.	60
Screwing cap	5 sec.	59
Wrapping, packing 12 oranges	15 m.	58
Folding newspaper for delivery	20 sec.	57
Folding used paper bag	10 sec.	56
Breaking, folding cardboard carton	5 sec.	55
Knitting piece 6″x6″	1 hr.	54
Walking around car applying air hose to tires	20 m.	53
Making bed	15 m.	52
Sixteen books, shelf	10 m.	51
Painting door surface	30 m.	50
Arranging six dollar bills, ten coins, cash box	20 sec.	49
Sawing 4′, 2″x4″	1 m.	48
Carrying case of empty qt. bottles 6′	1 m.	47
Stamping three library books	5 sec.	46
Filing 24, 5″x8″ cards	1 m.	45
Bit into brace	10 sec.	44
Drilling 2″x4″	1 m.	43
Extracting nail	1 m.	42
Nailing ½″ stock on 2″x4″	1 m.	41
Packing groceries, carton	1 m.	40
Wood, vise	10 sec.	39

*On the right hand side of the chart, there is space allowed for *graph*, *time* and *date*.

Age Level	*Reference*	*Related Work*	*Inventory List*	*Time Allowance*	*Number*
		Window cleaner	Cleaning window 6'x8'	30 m.	38
6	(1)	Mason's helper	Mixing mortar	30 m.	37
		Painter's helper	Stirring paint	30 m.	36
		Telephone operator	Plug into outlet	3 sec.	35
6	(1)	Laundress	Ironing, folding hand towel	1 m.	34
6	(1)	Laundress	Ironing handkerchief flat	30 sec.	33
6	(1)	Dish washer	Washing table setting for four	30 m.	32
6	(1)	Gardener	Mowing lawn 6'x8'	30 m.	31
6	(Observation)	Dish washer, restaurant	Unloading automatic dishwasher	20 m.	30
5	(Observation)	Dish washer, restaurant	Loading automatic dishwasher	20 m.	29
		Dish washer, restaurant	Food particles from plate	5 sec.	28
		Janitor	Opening lock	2 sec.	27
		Painter's helper	Lid on paint can	20 sec.	26
5	(1)	Furniture refinisher	Sanding table surface	30 m.	25
5	(1)	Piecework	Sewing seam 36"	10 sec.	24
5	(1)	Mother's assistant	Dusting table, chair	20 sec.	23
5	(1)	Mother's assistant	Washing three potatoes	5 m.	22
		Sexton	Shoveling snow, sidewalk 50'	30 m.	21
		Yard boy	Watering grass 6'x8'	30 m.	20
5	(1)	Odd job man	Sweeping sidewalk 50'	30 m.	19
5	(1)	Small store	Sweeping floor 8'x8'	15 m.	18
5	(1)	Office cleaner	Washing floor 6'x8'	30 m.	17
		Cleaning serviceman	Polishing floor 6'x8'	30 m.	16
5	(1)	Janitor	Waxing floor 6'x8'	20 m.	15
5	(1)	Housekeeper	Vacuuming rug 6'x8'	15 m.	14
5	(1)	Baker	Paring, coring three apples	10 m.	13
		Newspaper vendor	Opening bundle six newspapers	5 sec.	12
		Newspaper dealer	Rolling, tying six newspapers	5 m.	11
		Librarian's assistant	Pasting three library pockets	5 m.	10
5	(11)	Gift wrapper	Wrapping, tying with bowknot	5 m.	9
4	(11)	Super-market clerk	Replacing ten, 8-oz. cans in rack	30 sec.	8
		Baker	Rolling dough, fitting to pie tin	20 m.	7
3	(11)	Cook	Liquid in 8-c. saucepan	30 sec.	6
2	(11)	Abstracter	Turning all pages 12-page book	20 sec.	5
2	(11)	Railroad porter	Three suitcases in wagon, 30'	2 m.	4
18 mos.	(11)	Canner	Filling qt. jar with tomatoes	1 m.	3
18 mos.	(11)	Grocery store clerk	Stacking three cereal boxes	10 sec.	2
18 mos.	(11)	Night watchman	Key in padlock	5 sec.	1

cerebral palsied. They were able to get to and from the occupational therapy room within five minutes each way. Five move adequately in the upright position without crutches or canes; two use crutches; two, wheelchairs. One is a hemiplegia, one a triplegia, and seven are quadriplegias. The types are: five spastic, one athetoid, one ataxic and two rigidity. Four are boys, five girls. One is considered a normal school child, four retarded and four deficient. All were tractable subjects.

Information has been assembled in Table I, entitled, "The Nine Subjects: Description and Scores." The information is arranged under the following headings:

Age as of 3-27-52
Birth, date and sex
Type and disability
Locomotion status
Admission date
1937 Binet, Form L
Education status for September, 1952
Elementary motor skill score and date
Daily activity score and date

Timing. The time allowances listed are arbitrary. They may accrue significance as the inventory develops. All items were timed.

Taking Inventory. The occupational therapist took the inventories between March 3 and 27, 1952. All tasks were explained in relation to "home" and "mother," since all but two of the group were at first- and second-grade levels. Each child was put through each activity passively then actively due to the children's unfamiliarity with the skills and their lack of initiation of any activity without this procedure.

Scoring. Scoring was as follows:

Black block—task completed. Motor skill adequate for training.

Half black block—task not completed. Motor skill adequate for future re-checking.

Checkmark—no motor skill.

Scores were not based on endurance, speed, experience, thinking.

RESULTS

Results are in Table II, entitled, "The Nine Subjects: Pre-Vocational Motor Skill Inventory Scores and Results." Headings used are:

Pre-Vocational Motor Skill Score and Date
Completed Item Time
Total Time
Observations of Examiner 3-27-52
Observations of Examiner 5-29-52
Work Potential 3-27-52
Work Potential 5-29-52
Identification

The column entitled, "Observations of Examiner, 5-29-52," contains comments following a two-month occupational therapy program based on the pre-vocational motor skill inventory results (see Figure 2).

A comprehensive picture of the child may be drawn by using this inventory together with the other twelve inventories of motor status, reports from schoolroom teacher, speech therapist, physicians, medical social worker, psychologist and other total-rehabilitation specialists. Thus may an estimate of the child be made in terms of some work potential classification such as the two categories of place and earning powers:

Place	*Earning Powers*
World of occupations	Family-supporting
Sheltered workshop	Self-supporting
Home	Partially self-supporting
Institution	Economically dependent contributing work
	Economically dependent contributing nothing

The "Work Potential" column, Table II, contains such estimates for the nine subjects.

CONCLUSIONS

The function, prerequisites, needs and use of the inventory are outlined as follows:

1. The inventory requires a variety of motor work-skills which might point the way toward a better choice of pre-vocational subjects for the training program of the disabled person.

2. A pre-vocational program should be in the hands of trained professional personnel. If used with cerebral palsied patients, the examiners need to be thoroughly familiar with cerebral palsy. This is because the cerebral palsied patients require special presentation of a task to them probably due to their limited experience and training, mental capacity (if such is impaired), as well as possible distorted thinking processes (if brain injury[18] has interfered therewith).

3. The actual attainments of cerebral palsied children whose inventories are being taken now may lead to better methods of appraising their potentialities.

4. For adults this inventory is likely to yield similar results if used in a total-rehabilitation setting.

Courtesy of Eastern New York Orthopedic Hospital-School, Inc. (Sunnyview), Schenectady, New York.

Figure 2. Children in the pre-vocational program at the Cerebral Palsy School, Schenectady, New York, directed by Mrs. Mary van der Bogert, occupational therapist, right. Arrangements were made with the store owner, third from right, to allow classes in store duties such as seen here and also marking and stacking packages, replacing and counting returned bottles, making cardboard cartons. The children are from left to right 10-*J*, 13-*M and* 17-*Q*.

5. The dependence of motor work-skill development upon daily activity adequacy is evident, specifically in getting to and from the occupational therapy room and moving from place to place therein, changing position, taking care of toilet needs and washing hands.

6. Lack of work habits shows up plainly.

7. The number and combination of extremities used effectively may have significance.

8. The head may be considered an extremity useful to work skills.

9. Not only instructions and demonstrations but also practice periods, are indispensable to effect performance.

10. More complete anecdotal reporting of work-skill inventorying, methods and progress may yield hidden points.

11. In order to get more experience with more subjects, standardization of equipment, time allowances and instructions should be done.

12. The most effective execution of the inventory and interpretation of results are by the occupational therapist.

13. The inventory's results provide actual occupational performance data to the team which may serve in formulating a logical work plan along with data supplied by all other members of the total-rehabilitation team.[24,25]

SUMMARY

A one-hundred-item pre-vocational motor skill inventory has been tried with nine cerebral palsied children between the ages of eight years one month and thirteen years seven months at the Cerebral

TABLE I. THE NINE SUBJECTS: DESCRIPTION AND SCORES

Age as of 3-27-52	Birth Date and Sex	Type and Disability	Locomotion Status	Admission Date	1937 Binet, Form L	Education Status For Sept. '52	Elementary Motor Skill Score and Date		Daily Activity Score and Date	
8-1	2-2-44 M	Spastic Triplegia	Upright	10-24-51 (first educational experience)	10-11-50 CA 6-8 MA 6-0 IQ 90	(retarded) 2nd grade regular public school class	97 97	10-16-50 5-12-52	67 79.5 91.5	10-19-50 11- 5-51 5-12-52
9-4	11-22-42 M	Rigidity Quadriplegia	Upright	9-12-49	11-4-48 CA 5-11 MA 4-3 IQ 72	(retarded) Special class for slow learning	82 90 90	6-20-50 5-24-51 5-24-52	82 83.5 85.5 88 90	3- 3-50 6- 8-50 11-28-50 5-25-51 6- 5-52
9-8	7-21-42 F	Spastic Quadriplegia (Convulsions)	Upright	11-3-47	8-8-51 CA 9-1 MA 4-6 IQ not given	(deficient) Ungraded. Remaining in special class for C.P.	70.7 80.2 80.2	6-14-50 5-31-51 6- 2-52	59 61 69.5 72.5 82	3- 3-50 6- 8-50 11-29-50 5-29-51 6- 2-52
10-1	2-13-42 F	Athetoid Quadriplegia	Wheelchair	11-3-47	2-11-50 CA 8-0 MA 8-0 IQ 100	(retarded) Ungraded. Remaining in special class for C.P.	68 70	5-25-51 6- 5-52	15.5 15.5 20 33.5	3- 1-50 6- 8-50 6- 5-51 6- 5-52
11-0	3-3-41 M	Ataxic (?) Quadriplegia	Upright	12-18-47	6-8-50 CA 9-3 MA 4-2 IQ not given	(deficient) Ungraded. Remaining in special class for C.P.	88 88 88	6-15-50 5-28-51 6- 5-52	62.5 63.5 77 79.5	3- 3-50 6-14-50 5-24-51 6- 5-52
11-0	3-10-41 M	Spastic Quadriplegia	Upright 2 Crutches	9-13-48	2-14-50 CA 8-11 MA 8-10 IQ 99	(retarded) 4th grade regular public school class	92 95 95	6-19-50 5-31-51 6- 5-52	65.5 72.5 80.5 83 87.5	3- 3-50 6-15-50 11-28-50 5-31-51 6- 5-52
11-7	8-2-40 F	Spastic Left Hemiplegia	Upright	5-11-51	No data	(normal) 7th grade regular public school class	100	3-12-51	89.5 89.5	5-28-51 6-13-52
12-7	8-19-39 F	Spastic Quadriplegia (Arrested hydrocephalus)	Upright 2 Crutches	1-4-49	10-16-46 CA 7-2 MA 5-4 IQ 74	(deficient) 3rd grade. Remaining in special class for C.P.	80.7 92 92 92	6-15-50 12- 5-50 5-28-51 5-19-52	63.5 65 70.5 81 85.5	3- 3-50 6-16-50 11-28-50 5-25-51 5-19-52
13-7	8-26-38 F	Rigidity Quadriplegia	Wheelchair	1-12-48	6-15-50 CA 11-10 MA 4-8 IQ not given	(deficient) Ungraded. Remaining in special class for C.P.	75 78 78	6-19-50 5-21-51 4-29-52	9.5 12.5 14.5 32 46	2-24-50 6- 8-50 11-28-50 5-23-51 5-26-52

TABLE II. THE NINE SUBJECTS: PRE-VOCATIONAL MOTOR SKILL INVENTORY SCORES AND RESULTS

Pre-Vocational Motor Skill Score and Date		Completed Item Time	Total Time	OBSERVATIONS OF EXAMINER 3-27-52	5-29-52	Work Potential 3-27-52	5-29-52	Identification
95	3-21-52	8.5 hrs.	9 hrs.	All work of good quality. Appears to have good eye-hand coordination.	Seemed exceptionally like normal child. Uses entire self	World of Occupations	World of Occupations	17-Q

TABLE II. THE NINE SUBJECTS: PRE-VOCATIONAL MOTOR SKILL INVENTORY SCORES AND RESULTS

Pre-Vocational Motor Skill Score	and Date	Completed Item Time	Total Time	OBSERVATIONS OF EXAMINER 3-27-52	5-29-52	Work Potential 3-27-52	5-29-52	Identification
95	3-21-52	8.5 hrs.	9 hrs.	All work of good quality. Appears to have good eye-hand coordination.	Seemed exceptionally like normal child. Uses entire self. Stumbles and falls more than average boy. Cannot lift heavy objects with left hand alone. However, is able to lift case of 12 empty quart bottles and carry six feet. (Item No. 47).	**World of Occupations.** Good in many fields.	**World of Occupations.** Any fields other than those calling for fine skills for both hands.	17-Q See Figure 2
77.5	3-21-52	7 hrs.	9 hrs.	Quality forsaken for speed. In tasks where there has been training, quality improves. REACTION: "This is easy." "How did I do?" "Oh boy, what fun!" "Can I stay an hour tomorrow?" "I am going to be a painter. You show me how and I will paint your room."	Has good lower extremities. Hands are strong for lifting and perform well for most daily activities.	**Sheltered Workshop.** Supervision. Simple occupation.	**Sheltered Workshop.** Supervision. Simple occupation.	13-M See Figure 2
52.5	3-21-52	5.5 hrs.	9.5 hrs.	Gives acceptable jobs when supervised. Lack of successes does not come entirely from being unable to handle materials. Response to teaching is one of gratitude. Devises ways to accomplish tasks on her own. Liberal use made of her mouth, body weight, vise, chairs, a drill to start a nail. REACTION: On time for inventory at 9 a.m. which meant taking off outside clothes, a task that usually takes half the morning. By sign language indicated that she would like to learn to be a "matron," **not** a mother's helper, not have her own family.	Is cleaning acceptably with less supervision.	**Home.** Supervision.	**Home or Institution. Economically Dependent Contributing Work.** Supervision.	1-A
38	3-21-52	4.5 hrs.	9.5 hrs.	Uses the vise, her mouth and body to do her work. At home earns an allowance by caring for own room, cleaning kitchen drawers. REACTION: "This is easy. I do this at home." Checked in wheelchair. Slides self into chairs or onto floor when necessary.	Is washing dishes, ironing own clothes, setting table and making beds at home. Is making dress on electric sewing machine at school. Serves food in lunchroom. Family buying her an electric sewing machine.	**Home. Economically Dependent Contributing Work.** Limited Housework.	**Home. Economically Dependent Contributing Work.** Limited Housework.	7-G See Figure 1
46.5	3-21-52	4 hrs.	8.5 hrs.	Gives up easily. Recognizes where he is apt to fail. Works best when only one extremity is called upon at a time. REACTION: "I like you. I am going home with you."	Uses one extremity at a time and apparently has poor eye-hand coordination. Responds to daily training; slow and feels lack of successes. Desires to help at small store.	**Home.** Supervision. Limited Housework.	**Home. Economically Dependent Contributing Nothing.**	10-J See Figure 2
78.5	3-21-52	5 hrs.	9.5 hrs.	Discards crutches. Leans against furniture or walls. Falls. Works on hands and knees or sitting in chair. REACTION: "You have opened my eyes to a new thought. I am going to be a butcher." "I think I will earn money now and be a shoeshine boy." "My mother and I have talked it over. I am going to be a TV repair man so I will start studying electronics."	Falls without crutches, making some vocations dangerous. Crutches limit some other possible vocations. Has reasonably good use of both hands and eyes with hands. Responds quickly to training.	**Sheltered Workshop.** Seated occupation.	**Sheltered Workshop.** If seated, in any gross two-handed work.	15-0
92.5	3-21-52	7 hrs.	8 hrs.	REACTION: "Oh, isn't this fun! When can I come again?" Making dress for self and wooden chest.	Uses right hand with partial use of left. Legs are good though scar surface on left leg prevented sawing the 2 in. x 4 in.	**World of Occupations.** Good in many fields.	**World of Occupations. Self-supporting.** Partial use of left hand.	4-D
62	3-21-52	10 hrs.	13 hrs.	Could manage some tasks better if wheelchair or rolling chair were provided, since she cannot stand without support from crutches or furniture.	Wheelchair necessary for occupational advancement. Housework, ironing men's shirts, sewing by hand and by machine with supervision.	**Home.** Supervision.	**Home. Economically Dependent Contributing Work.** Supervision.	11-K
31	3-21-52	6.5 hrs.	13 hrs.	Uses wheelchair with feet for locomotion. Stands by locking wheelchair behind her when necessary. Slides to floor for some activities. A strong reflex, throwing hand with contents; occurs when working with heat, water, crockery. REACTION: "How can I help Mummy?" "If I do this, this will help."	Desire for independence is increasing; mother reports child making beds, washing table silver, dressing self on week-end days.	**Home.** Supervision. Limited housework.	**Home. Economically Dependent Contributing Nothing.**	3-C
			9.4 hrs. average					

THERAPY REPORT OF MOTOR STATUS

(This report is part of Appendix I)

Eastern New York Orthopedic Hospital-School, Inc. (Sunnyview), Schenectady, N. Y.

THERAPY REPORT OF MOTOR STATUS NO. 1 — AUGUST 4, 1952

NAME:	G - - - - - -, L - - - - - -	*DIAGNOSIS:*	Cerebral palsy, spastic type.
BIRTH DATE:	12-31-32	*DISABILITY:*	Quadriplegia (all four extremities), speech mildly impaired.
REASON FOR EVALUATION:	To comply with request of . . . , for information to serve as a motor guide to those attempting to give pre-vocational or vocational guidance or training.	*EVALUATION STAY IN HOSPITAL:*	Number of days—12. Number of staff hours spent on evaluation—36½.

WORK TRAINING POTENTIAL: This report is based on physical and occupational therapy data. Psychological, educational, social and work histories and reports have not been obtained and are indispensable in estimating this boy's abilities and prospects. The results of the inventories, essentially motor, to which the young man has been subjected, reveal him to have essentially adequate daily activity skills but limited motor work skills, as judged by the one hundred items which were presented to him on the pre-vocational motor skill inventory. The relatively extensive, though incomplete, motor exploration herein suggests that, after further exploration and training at a vocational training school or center where there are vocational training facilities, for a period impossible to predict, this young man might be able to earn at least a partial living in a sheltered situation at work requiring only gross skills, provided placement could be secured. It is impossible to designate any specific occupations for training other than to give the pointers below.

INVENTORIES AND SCORES:

Range and Strength	....	7-22-52	Copies
Elementary Motor Skill	90	7-22-52	of
Daily Activity	92½	7-31-52	work-sheets
Clothing	....	7-25-52	were
Food Intake	....	7-28-52	enclosed
Grasp and Release	100	7-28-52	with this
Pre-Vocational Motor Skill	80½	7-28-52	report

RANGE AND STRENGTH: The following are essentially normal: upper extremities, head and neck, backward and twisting motions of the trunk and raising upper extremities overhead. Trunk range and strength are mildly impaired on the front, abdominal muscles being slightly weak. He lacks a few degrees toward attaining a fully upright sitting posture with lower extremities outstretched. There is no flexibility in the low back so he cannot raise and lower the pelvis but this is not handicapping to him. Raising and lowering shoulder girdle are limited in range and strength but not to any seriously impractical degree. The greatest impairment of motion is in the lower extremities in all joints, the major handicapping features being his stiffness and lack of strong control, balance and speed. However he has sufficient muscle power to move one foot in front of the other and clear the floor to take steps and also straighten his knees. Ankles are fused for stability which allows for satisfactory foot placement.

ELEMENTARY MOTOR SKILL: *Score*=90. All activities were accomplished except standing without support and moving tongue up and down.

DAILY ACTIVITY: *Score*=92½. He was unable to accomplish two activities: folding paper and placing in envelope and sealing, and tying a necktie. No credit was given for getting on a bus as it took over twice the allowed time (10 m.), but he was able to accomplish this with only a little difficulty in 22 m. Half credit was given for the following activities because of his lack of speed: readjusting clothing following toilet activities on bed and standing; walking sideward and backward; drawing a straight line with a ruler and cutting with scissors; getting out of bus and going up a curb. Of those accomplished, all were completed with ease except stairs without a handrail which were difficult due to unsteadiness. Although shaving motions are present, there is notably a lack of skill.

Travel Trip: He was taken on two travel trips. On the first trip he walked one-half mile to a drug store, crossing streets in traffic at traffic lights, going up and down curbs varying from 4 inches to approximately 10 inches in height. In the drug store he handled a rotating counter stool with some difficulty, ordered and ate an ice cream sundae. On the return trip he followed a sidewalk about half way and then walked through extremely high grass over rough ground to the back of the hospital. He had a little difficulty tripping in the grass but was able to make both trips (to and from hospital) without a rest. The second trip covered the same area but he took a public bus for 3/10 of a mile. He boarded the bus, paid his fare and seated himself slowly but without assistance. Main difficulties observed were: lack of speed, wide base of crutches making passing others on sidewalk difficult, difficulty placing crutches in drug store and on bus, feet and crutches protruding in aisle on bus and in the way of other passengers.

CLOTHING: During the testing periods he wore the following clothing: sleeveless undershirt, elastic-top shorts, plain rib socks, low laced shoes, loose knit "T" shirt, blue jeans with zipper, snap and belt.

FOOD INTAKE: He eats in an acceptable manner for a public restaurant. He can manage all foods. He can serve himself and carry one plate of food. A tray is not possible at this time.

GRASP AND RELEASE: *Score*=100. Hand grasp and release are strong.

PREVOCATIONAL MOTOR SKILL: *Score*=80½. Four levels of motor performance are shown, together with suggestions. A study of each level follows.

I. *Completed Items in Good Time*:
1. Household tasks predominate.
2. He might be prepared for some phases of masonry on a small scale.
3. He can iron flat by hand and could be taught to fold more accurately. Thus laundry work might be a field for training.
4. Household-painting might be possible with no climbing.
5. He has the ability to pack fruit.
6. Assisting in a library might be possible.
7. He could help in a restaurant kitchen washing dishes by hand or automatically.
8. Refinishing antiques might be a possibility.

II. *Completed Items in Slow Time or of Poor Quality*:
1. Fine skills appear difficult though some are possible.
2. Gross skills are generally successful.
3. He can stoop, reach overhead, carry, push and lift while using one (only) forearm to support Canadian crutch.

III. *Uncompleted Items*:
1. Eye-to-hand coordination is present but delayed and calls for considerable effort.
2. Strength in sawing motions is present for short periods.

IV. *Items in Which No Skill Whatsoever Was Shown*:
1. He lacks two-point standing balance; kneeling balance is insecure in a working situation.
2. He lacks individual finger use.
3. He lacks ability to use two hands at once in skills.
4. Eye-to-hand coordination is delayed.
5. He lacks the ability to lift either foot off the floor in a seated position.

(He reports the following: he now holds the only job he has ever had, which he secured through his own efforts. It is a two-day-a-month job folding and placing 4009 one-half-sheet statements plus advertisements in envelopes. Works with two other non-handicapped helpers (a machine seals and stamps). He earns $8.15 a month ($6.43 net). His hours are 9:30 to 5:30 with an hour for lunch. . . . He reports the Personnel Manager says she wants to train him in switchboard work. He had originally wanted to become a switchboard operator or elevator man when he started on this job.)

APPLIANCES, SHOES, LOCOMOTION AIDS, SPECIAL EQUIPMENT: *Crutches*: Metal forearm-supporting Canadian crutches. The cuffs have irritated the skin, creating a burn, and marks indicate this has happened previously.
Shoes: Low laced.

GAIT AND POSTURE: His gait is adequate with Canadian crutches, though a large space is needed. His left shoulder is lower than the right, and the left shoulder blade is prominent. His entire body is tilted slightly forward and he leads slightly with the right side of his body. When walking the pelvis appears to be level. The left lower extremity is held in external rotation and is carried out and around and then placed straight forward on the floor with a slapping of the forefoot when taking a step. There is a tendency toward back-knee when weight is borne on the left. The right lower extremity is also held in external rotation when taking a step forward, and when weight is shifted to the foot it pivots and goes into increased toeing-out position. The right knee is maintained in slightly bent position.

PERSONAL HYGIENE INCLUDING TOILET: *Grooming*: Although he appears clean, he has a somewhat untidy appearance. His clothing especially has a very rumpled, ill-fitting appearance.
Toilet: Completely independent but slow in rearranging present clothing.

SPEECH: His speech is slow and somewhat impaired but essentially clear.

BEHAVIOR OBSERVATIONS: *By physical therapists*: He is an extremely friendly, well mannered young man who was readily accepted and liked by other patients and staff members. He has a special facility for use of unusually courteous language and also appears to have especially good judgment as to the proper manner and the right thing to do. He appeared to comprehend most directions and is a willing worker. It should be noted however that the activities required were relatively easy ones for him. He did give indications of not being realistic in regard to his capabilities and future possibilities. An example was experenced upon presenting the inventory results to him. He accepted the

explanation in a glowing manner saying it was a wonderful report. It was apparent he had confused friendliness with the facts and seemed to leave with an over-optimistic view of his school possibilities.

By occupational therapist: He is a well mannered, pleasant young man with a well developed sense of right and wrong. Concern with reactions of the person or persons about him along with a constant verbal flow (often not related to the task at hand) interferes with the understanding and accomplishment of the task.

RECOMMENDATIONS:

1. That metal crutch cuffs be covered with leather to protect his skin and thus prevent irritated areas.
2. That his clothing be selected with ease and speed of handling as well as attractiveness in mind: example, boxer-top trousers necessitating no belt.
3. That the need for immaculate grooming to offset his obvious physical disabilities be stressed, and that he be taught how to shave acceptably and tie a necktie (a selection might be tried to find the most manageable and suitable type).
4. That he undergo a vigorous daily activity program including,
   a. Practice on stairs without a handrail.
   b. Concentrated balance work in sitting, kneeling and standing positions, since he showed marked unfamiliarity and real difficulty in managing his own balance and performing motor-work skills with tools. The situation is complicated by his crutches when standing and changing position especially if there are tools to manipulate.
   c. Drills to give him skill in crutch-placement while walking and sitting especially while at work or in a bus.
5. That he use a push-broom for sweeping because three-point balance is needed.
6. That he use a tank-type cleaner and waxer (he uses a Hoover-type at home), because three-point balance is needed.
7. That he continue with his excellent housekeeping program inasmuch as he has displayed his greatest skill in these items.
8. That if there are means he be sent to an institution offering further exploration of his work capacities or a vocational training school or a center offering vocational training where complete professional services are available.
9. That this report accompany him there to serve as a motor guide to the staff and to supplement the psychological, educational, social and work histories and reports which should be obtained.
10. That complete records of his educational and psychological status, as well as any work history, be obtained for use in further evaluation as such information would have even more effect upon his work future than the motor components partially indicated herein.
11. That he be encouraged to look into club possibilities, such as the Y.M.C.A., for recreational activities.
12. That the inventory worksheets be studied in case of interest in the specific activities checked. (The inventory scores are based on the activities listed and not on the basis of a score of 100 equalling a "normal" score.)

8-4-52	Summarized by (signed) and
Date	BETTY O. NICHOLS, P.T.
8-4-52	(signed)
Date	MARY ELEANOR BROWN, P.T. *Director of Professional Services*
8-4-52	(signed)
Date	Physician

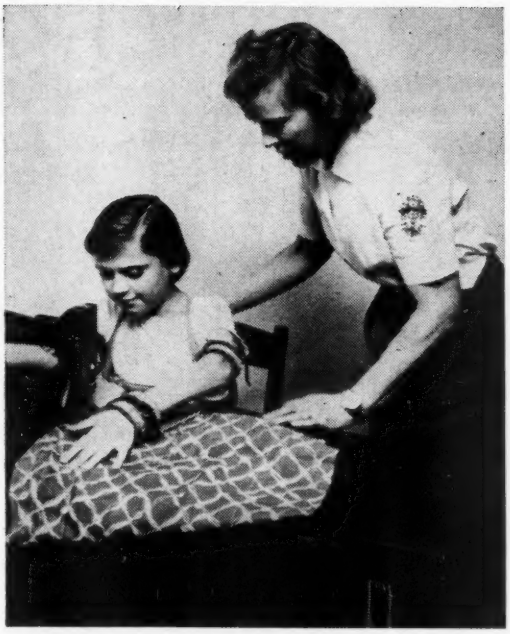
Palsy School, Schenectady, New York. This instrument is one of a series of thirteen to serve as worksheet guides for estimating the motor status of a person with motor impairment. The inventory is in its first stages of development.

The function of the pre-vocational motor skill inventory in an early work-skill program and requisites therefor are outlined in their relation to total rehabilitation.

The order of events suggested for the development of such a work-skill program is as follows:

1. Satisfy the daily activity requirements.
2. Take inventory of motor work-skill potentials.
3. Set up a work-skill program on the basis of inventory results and in line with actual community facilities.
4. Train for a specific occupation available in the community.

The pre-vocational motor skill inventory is likely to be most valuable as a pre-vocational guide to those striving to prepare cerebral palsied for future work.



Courtesy of Eastern New York Orthopedic Hospital-School, Inc. (Sunnyview), Schenectady, New York.

Figure 3. Mrs. van der Bogert, O.T.R., supervises a ten-year-old girl with partially paralyzed upper extremities supported by a Sunnyview brace, as she works on her self-help skirt. Her pre-vocational motor skill inventory results (especially Items Nos. 24, 65, 73 and 86) led to pursuing sewing as one of her occupational therapy activities. The elasticized waistband encourages independence in dressing and allows attractive combinations of colored T-shirts and skirts.

APPENDIX I.
THERAPY REPORT OF MOTOR STATUS

A copy of a therapy report of motor status is to be found on pages 160-162. This was made after a motor evaluation of a nineteen-year-old cerebral palsied young man was carried out by inventories, including the pre-vocational motor skill inventory. It is the first time that the pre-vocational motor skill inventory had been used with an adult. A medical report accompanied this report. It is important to bear in mind the preliminary character of this motor status report. Subsequent similar attempts at motor evaluations may reveal new and better ways to obtain the needed information. The authors would welcome questions, comments and criticism of all this material.

APPENDIX II.
THE NON-CEREBRAL-PALSIED

The pre-vocational motor skill inventory is presently serving other than cerebral palsied at Sunnyview Hospital, some of whom are post-poliomyelitic (see Figure 3).

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(*Continued on page* 188)

DRAMA AS AN AID TO THE PSYCHOTHERAPIST

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INTRODUCTION

Drama is not a new procedure in the treatment of the mentally ill and has always been considered as one of the components of occupational therapy. This probably resulted from an identification with occupational therapy through the process of doing and endeavoring to influence the well-being of the individual by his contact with others in co-operative activities. The utilization of this to the utmost means a constant alertness to integrate into itself the formulations and concepts revealed by the unceasing investigations into the nature and structure of mental illness.

If we ask ourselves, "what are the eventual goals of all these activities?" an answer which has found favor with us is Saul's[1] formulation of emotional maturity. In his definition he gives the following eight characteristics: (1) Predominance of independence and responsibility with little need to regress. (2) Predominance of giving and productivity although with the capacity to receive normally. (3) Lack of egotism and competitiveness. (4) A well integrated conscience which furthers development. (5) Sexuality free and integrated with mating and responsible, productive activity. (6) Hostility towards self and others minimal but freely available for defense and constructive use. (7) Grasp of reality unimpaired by persisting childhood reactions and (8) freedom from childhood pattern reactions and hence full capacity toward discrimination and adaptability.

To achieve this completely or even partially means a continuous effort in overcoming a multitude of intervening resistances, both recognized and unrecognized. Resistances as used here means those forces which bring about an endless repetitiveness of the patient's behavior and whose resolution is usually accompanied by anxieties of varying degree. For example, we know the formidable problem that is felt by patients in accepting the concept that they have an emotional disorder. In the same direction, the degree to which the patient will accept a dynamic formulation of his disturbances varies greatly.

For many patients it is a much safer way to attempt to resolve their anxiety-ridden personality difficulties initally through the vector of "doing" with such aids as occupational therapy, the arts, the crafts and play than to make a point blank assault through psychotherapy. Drama has always had an appeal because of its approach to the deeper feelings through play, and as we know, this is not new. However with the introduction of the concepts of modern dynamic psychiatry its use as a vehicle for maneuvering the patient into a position of psychological awareness was developed very intensively by Mareno[2] and his co-workers. He believes that this form of psychotherapy—which he calls psychodrama—can be utilized in various ways. In this process the auxiliary egos undertake the function of helping the patient step by step to achieve a level of maturity. Spontaneity is one of the most fundamental principles in psychodrama. He also points out the possibility that complete spontaneity and freedom of action might lead sometimes to the deterioration of the psychotherapeutic process. To avoid a disintegrative process from setting in, the acting is controlled through the use of trained assistant personnel called "auxiliary egos."

OBSERVATIONS

A drama unit was organized around Mareno's concepts of psychodrama at the Spring Grove State Hospital three years ago. This group, which is called psychodrama, has been of a continuous type with patients entering and leaving the group at their own discretion. The group is a mixed one consisting of males and females of all types of diagnostic classifications but made up for the most part of patients who have a schizophrenic process. The group meets twice a week for a two-hour session in a special room. This room, which is extra large, is equipped with a small platform which acts as a stage. The ceiling is soundproofed and microphones are fixed in positions to record what goes on in the room. These microphones connect with a tape recorder. About a dozen comfortable chairs and smoking stands make up the furniture.

The therapist conducts the group in a very passive, permissive manner with a non-directive approach allowing the patients to work out anything that may come to their attention at the moment. As it is seen, one would say it fell somewhere between the psychodrama of Mareno and group psychotherapy. What it specifically accomplishes for the patient is extremely difficult to evaluate in any quantitative manner. However we do know this: as an activity it creates more discussion among the patients than anything else they are exposed to in the hospital and is a very active socializing procedure. Similar observations in this area have been the experiences of Parrish and Mitchell[3] also working in a state hospital setting.

Some of the problems which have presented themselves as the group has evolved in its course and to which there are no definite or complete answers at this time are indicated by the enumerated list of topics such as: (1) getting patients to attend and their attitudes; (2) the doctors' attitudes; (3) the kinds of patients who seek this type of activity; (4) the introduction of drama therapy to new patients; (5) specific management problems such as permissiveness versus active direction, handling impulsives, neckers, those who walk out, etc; (6) acting versus talking; (7) the use of volunteers; (8) the director's role toward individual patients as well as the entire group. Often he must simultaneously play roles of father, mother, super-ego, ego substitute, protector, castrator; (9) the types of problems presented: repressing anger, gossiping on the ward, homosexuality, sexual discussions, struggles for autonomy from parental control, fears and sexual fantasies surrounding individual psychotherapy, helplessness on the basis of id impulses (fear of hypnosis) necessitating a great deal of discussion on this topic; (10) normality and mental illness—how they differ; (11) hurting self and hurting others; (12) catharsis of problems leading to commitment; (13) attitude of patients toward drama therapy; (14) reaction of different diagnostic categories of patients to drama and suggested handling; (15) reaction of these patients to individual therapy—is drama a help, is it a hinderance, is there no effect; (16) what is the attitude of the therapist; (17) the difficulties of evaluating the benefits of drama therapy; (18) group dynamics.

As can be seen each of the topics listed presents a study all in itself. In addition drama is an excellent setting in which to observe the differences in personalities even though they all have common labels. It offers an opportunity for acquiring information both as to the adjustment of the patient in the hospital, his potentialities for getting along on the outside and what insights he is developing from the therapy or therapies he is receiving.

If we take the schizophrenics as a group and attempt to evaluate what they have been able to do in this situation, a number of interesting observations come to light. The schizophrenic patient's ability to take part range over a wide gamut of reactions from getting upon a stage and playing a role to the paranoid patient who prefers to isolate himself in a corner of the room and suspiciously observes what is going on. In those paranoids who take part, one sees the keen ability and sensitivity to the details of the personalities they are trying to portray.

One paranoid patient (C.P.) after being urged for two or three weeks to take a role on the stage, spontaneously volunteered to imitate one of the other patients who happened to be absent on that day. The patient that she imitated was one who always evoked a great deal of hostility in the patients by her aggravating behavior. This paranoid was not only allowed to imitate the absent patient but auxiliary egos were provided to facilitate her imitation. During the imitation this patient exaggerated her movements on and around the stage, using facial expressions and vocal intonations not only characteristic of the absent patient but with almost exact definition. Many of the absent patient's own statements and verbal expressions were quoted.

The entire display was given good humoredly but there seemed to be an undertow of hostility in it which was crystallized by other schizophrenics in the following session. They felt some apprehension for taking part in the imitation and a great deal of feeling was expressed for and against it. The paranoid who imitated that session withdrew again and in a few weeks dropped out of the group, In later interviews she was cautious and evasive in talking of her reasons for dropping out and preferred to let the entire matter drop. No explanations could be obtained and it was felt by the director the situation might have been allowed to get out of hand allowing the patient to expose too much of her hostility. It was felt that this patient could have profited more from the experience had she been restrained to some degree.

Many paranoid patients who have participated freely give as their reason for taking part a desire to understand what the director is doing and how he goes about it. They become amateur psychologists paying a great deal of close attention to what is said and done and attempting to make interpretations of what is happening. They watch the therapist closely looking for opportunities to insert their comments on what the patient is doing or wants to do. These patients will be the first ones there at drama time and usually try to walk out with the therapist like an assistant.

On many occasions patients become involved in fantasies which eventually lead to emotionally laden situations in the past. The data discussed with the psychiatrist, who may be treating the patient in individual psychotherapy, sometimes leads to the introduction of this data in the psychotherapeutic situation with considerable catharsis and rewarding insights. For example, one schizophrenic girl was given a role of child to play in which she was to explain copulatory activity in animals that were supposedly observed and whose activity was misinterpreted by the other person acting with her. She told a long story about lions

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THE THERAPIST-PSYCHOLOGIST TEAM IN PHYSICAL REHABILITATION

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While psychological factors are important in many phases of medicine, they are particularly important in the area of physical medicine and rehabilitation. Here the patient does not merely submit passively to various therapeutic procedures such as taking medicine, sitting under a lamp or allowing people to do things to him. The patient must take a more active role. He must *learn* to crutch walk, to care for himself or to use a prosthetic device. Under these conditions motivation, learning ability and other psychological variables emerge as factors of primary concern. It may be expected, therefore, that there would be a number of patients who are physically capable and yet who are unable to profit maximally from rehabilitation training. Indeed, patients who are fearful of crutch walking, who "refuse" to leave their wheelchairs or who are "too comfortable" in the hospital situation to learn to help themselves are not uncommon.

One of the major tools for overcoming these psychological difficulties is the patient-therapist relationship.[1] Unfortunately, the literature is all too vague on this important subject. It is discussed in such generalities as "it is important to form a good relationship with the patient." What a "good" relationship is, or how one can tell whether or not a relationship is "good," is rarely presented. General rules may be formulated for the majority of patients but each "problem" patient—and it is with the problem patient where a proper relationship is most necessary—must be approached differently.

One essential aspect of the patient-therapist relationship is the personality of the therapist himself. His own needs, attitudes and motivations are bound to influence his relationships with patients just as they influence his relations with all people. However, this aspect of the relationship merits a lengthy discussion and should be the subject of a separate paper.

The major determinant of the patient-therapist relationship, when used as a therapeutic tool, should be the psychological characteristics of the patient. It must be stressed that the overt behavior of the patient is merely a symptomatic expression of deeper psychological characteristics and is not synonymous with them. It is upon these deeper characteristics, the basic personality of the patient, that the relationship should be based. Thus patients presenting similar overt problems may require very different relationships with the therapists for optimal performance in the training situation.

The psychologist is in a position to furnish information regarding these deeper characteristics of the patients. The therapist, in turn, can provide behavioral data showing how these characteristics function in the training situation. With this information, the psychologist and the therapist, *working as a team,* can decide on the role the therapist is to play and the manner in which the training situation can be structured.

The experience of the rehabilitation services of the New York City Hospital and the Goldwater Memorial Hospital[2] is that the results of such teamwork can be most fruitful. The purpose of the present paper is to demonstrate, through the presentation of several cases, the functioning of this team. It will also show concretely how the personality characteristics of the patient may indicate the type of patient-therapist relationship that would be most beneficial and the goals these relationships may strive to achieve. The cases to be presented are from the rehabilitation services of the hospitals mentioned above.[3]

Case 1: The patient was a 36 year old man who was hospitalized for a dermatological condition. He had an above the elbow amputation of the right arm when he was fourteen years old, had no prosthetic arm and had not been gainfully employed for a number of years. He was transferred to the rehabilitation service to investigate the possibilities of vocational rehabilitation.

Investigation soon revealed that for several years some agencies had investigated the patient for this purpose but had decided he was unfit for vocational retraining because of "neurotic" difficulties. One agency actually did begin training but it was not successful because the patient was "lazy."

A psychological examination revealed that the patient was a beaten man. He was overwhelmed by his own inadequacies and inability to successfully handle his environment. So certain was he of failure that he was afraid to attempt anything. He had a feeling of being helplessly

1. Throughout the paper the word therapist will be used to include occupational and physical therapists.

2. Both of the New York City Department of Hospitals.

3. The authors' thanks are due to Miss M. Herzberg of Goldwater Memorial Hospital, Mr. M. Goldstein of City Hospital and Mr. P. Imre of New York University, who participated in the psychological examination of several of the patients to be discussed.

buffeted by a cruel world. Even more, he was so afraid of the cruel world he saw that he was afraid of exposing himself to it for fear of being beaten. So he did nothing and lived as a friendless isolate on the welfare rolls.

These attitudes became understandable in the light of his life history. He was a Negro, born in the deep south to eke out a bare existence. Finally, at the age of thirty, he gave up the struggle, migrated to New York City, to the welfare rolls and to a life without hope.

With these facts in mind, it was believed that the therapist-patient relationship should be characterized by an extreme gentleness, an acceptance and encouragement, interest and warmth. This would enable the patient to experience a relationship he had never before known. It might allow him to see that the world is not a completely hostile and fear-provoking place. The transfer to the rehabilitation ward, the interviews with the guidance counselor and psychologist were a good beginning for it showed him people were interested in him and did see assets in him. However, the major effort had to come from the therapists.

One occupational therapist began to teach the patient to read and write. She was friendly toward him and very gentle with him. She set limited goals in their lessons, gave constant encouragement and rarely did anything that might be considered a condemnation. He was allowed to volunteer for tasks about the ward and was complimented whenever he did anything. All members of the rehabilitation staff had a friendly word for him whenever they saw him.

The patient began to flower under this treatment. He made progress in learning to read and write. Far from being "lazy" he kept himself busy at many tasks. In due course of time he was referred to an agency for further vocational rehabilitation. He was sent for "work therapy" and the personnel at that agency were apprised of the facts. After completion of this therapy, he braved the world alone (for him a remarkable feat) and found a job as a building superintendent.

It was essentially the attitude of the therapists that made possible this progress. Only when the patient was able to experience a warm, non-punitive relationship could he have been induced to leave his shell and expose himself to the world. True, he may still be "neurotic" but now he at least has a chance for happiness, has gained some confidence and self-respect and is no longer a burden on the community.

The patient-therapist relationship formed in this case is one that is usually thought to be the "ideal." However, although permissiveness and warmth were indicated with this patient, there are times when a more authoritarian approach is necessary.

Case 2: An 80 year old man was hospitalized for low back pain. The pain was apparently so severe that the patient claimed he could not walk. Once in the hospital, he refused to leave his wheelchair and contractures started to develop in his knees. Medical examination revealed mild arthritic changes and the fact that one leg was shorter than the other. It was believed that these factors caused the pain, and that a lift on one shoe would relieve it. Yet when in therapy the patient refused even to stand, and when pressed, occasionally would urinate on the floor.

Psychological examination showed this patient to be essentially a passive-aggressive individual. He was basically interested in controlling and manipulating people and the technique he used for this purpose was to appear helpless and to refuse to do things for himself. This probably was a life-long pattern but was present in a modified form. The approach of senility, the realization that his powers in all areas were waning, precipitated a great deal of anxiety.

To adopt a permissive approach to this patient would be to play his game and he would never walk. He would just passively insist he couldn't walk and use this incapacity to manipulate people. Therefore it was decided to use an authoritarian approach. A husky male therapist was assigned to the patient and gave orders that were terse and sharp. Within the week the patient was ambulating with a cane and with no assistance. Within two weeks he climbed a flight of stairs with no assistance. He was sharply told not to urinate on the floor—and he stopped! In this way the goals of physical therapy were achieved, i.e., the contractures and increasing weakness were counteracted, the pain was alleviated by the use of a lift and the patient was prepared for discharge.

Thus when the patient was no longer able to utilize his pain to satisfy his psychological needs, ambulation training was able to progress. A potential custodial or nursing home patient was enabled to be discharged to his home.

Even when permissiveness is the main characteristic of the patient-therapist relationship, the aims of the relationship may vary. In the first case presented above, the aim of the relationship was to show the patient that the world was not a completely hostile place and to help him gain confidence in himself. In the following case, the aim of the relationship was to restore the patient's self-esteem and prestige status.

Case 3. This patient was a 61 year old woman. She lived with her husband and was in moderate financial circumstances. Her major occupation was that of a housewife. However she did lead an active social life and participated in a number of charitable societies and women's organizations. She was hospitalized for an intertrochanteric fracture of the right femur and a hip nailing operation was performed. Six weeks post-operatively the patient was transferred to the rehabilitation ward for training in non-weight bearing ambulation and eventually weight bearing ambulation. At the time of referral the patient was being given exercises and was being prepared for crutch walking.

Many comments were received concerning the patient's ward behavior. She did not get along with the ward personnel and antagonized them by her aggressive behavior and her "arrogance." In turn the patient constantly complained of the inefficiency and laxness of the ward personnel. She had little to do with other patients and when she did, a patronizing attitude was assumed. In the physical therapy exercise situation the patient was passively cooperative and was not making the progress expected of her. One very important aspect of her ward behavior was her crying spells. These occurred fairly often and usually took the form of sobbing into her pillow so that the ward personnel would not notice. When crutch walking training was started, the patient evinced so much fear that it hampered her progress.

The psychological examination showed that the patient had an idealized image of herself as "someone special." When analyzed, her difficulties with ward personnel and her complaints about the hospital almost all were reducable to the same core: she *should* get special treatment and consideration. There was the awareness of the fact that in reality she was not a special person, that the major part of her life was past and there was now little likelihood

of her ever achieving her idealized status. This awareness probably brought about her depression and her self-condemnation. However it must be noted that it was the hospital situation that actually precipitated these characteristics into overt behavior. Prior to the injury she had maintained an adequate adjustment. The patient's age, as well as the other general factors previously discussed, made infeasible a psychotherapeutic attack on her basic problems.

The goal of the patient-therapist relationship was to restore her self-esteem. The therapist was permissive and encouraging to the patient. Furthermore the therapists were to recognize unusual achievements on her part and to place her in positions of prestige because of them. Thus when the patient proved to be an expert in crocheting, special exhibits of her work were planned, and she was asked to instruct other patients. She was also given various other "prestige tasks" about the ward. The physical therapist had her help arrange schedules (actually an unnecessary task) and she also helped organize ward recreational activities. Discussions of her own medical status were kept on a "high" (i.e. an intellectualized) status which gave her the feeling that she was accepted as an intelligent and educated person. The patient's neurotic tendencies were quite severe and it would be too much to expect radical changes through this approach. Although still neurotic, there was some symptomatic relief. The depressive episodes became rare (but did not completel, disappear) and progress in crutch walking improved.

It must be noted that in these cases, the type of relationship needed was based, not on the superficial behavior of the patients, but on their basic personality. On the surface, two patients may appear to have similar problems, yet the indicated relationships with these two patients may be diametrically opposed. This was true of the two cases which follow.

Case 4: This patient was a 42 year old man with the diagnosis of posterio-lateral sclerosis. His overt behavior was characterized by a marked depression. His attitude toward rehabilitation can best be expressed in his often-repeated: "What's the use?"

The patient could never remember a time in his life when he was not depressed, tired and unhappy. As a child, he remembered, he never got enough to eat. As an adult, he never made more than a bare living as a retail merchant. He believed that most people, including his wife and young daughter, looked upon him as being inferior. He himself believed he was constitutionally inferior to most people and that he could not compete. He doubted his intelligence (which testing showed to be bright-normal), his ability to "influence people," and at times even his sanity. It is true that he was shorter and thinner than average and had never been athletic. These facts however were used as a basis for his belief that his illness was only the natural outcome of his physical inferiority. When the illness led to a paraplegia, he was completely convinced that he was "just not the same as everybody else."

The key to the therapist's approach to this patient was to be found in the recognition of these depressive tendencies as a chronic neurosis going deep to the roots of his personality. Allied with this depression was his inability to accept himself as a human being and as a worthwhile person. In this specific instance this was achieved through the medium of demonstrating to the patient that anything he had to say, no matter how trivial, was worth the therapist's time and attention. In practice this meant that the therapist had to spend a great deal of time conversing with the patient or listening to a recital of problems. Buttressed by constant praise and recognition, the patient's attitude changed from one of helplessness and despair to one of wholehearted cooperation and even enthusiasm.

Case 5: This patient was a 37 year old man with a ten year history of slowly progressing multiple sclerosis. At the time of his admittance to the rehabilitation ward he was becoming incontinent, had a marked intention tremor which made feeding himself a problem and had great difficulty in getting from bed to wheelchair.

His attitude towards rehabilitation also was: "What's the use?" When asked to cooperate with the therapist he would burst into tears. He was informed that his goal in rehabilitation was simply to improve his activities of daily living and his response was: "I'd rather die. Let me die." Attempts to become friendly only irritated him.

In his youth this patient had been a star athlete and had been offered the opportunity of becoming a professional ball player. Instead he became a very successful salesman. At the age of 27, when the neurological symptoms appeared, he had been told that he would be in line for the position of sales manager before he was 30. Psychological testing showed him to be potentially of bright-normal intelligence but with many indications of diffuse cortical damage. Although he had an essentially normal personality there was a tendency toward obsessions and brooding. His present behavior was interpreted as being a reaction to his disability and a hopelessness predominated by feeling sorry for himself.

With this background it was believed that the therapist's efforts to gain "rapport" were interpreted as pity and condescension which would only increase his own despair. The therapists therefore adopted an approach that was as business-like, brisk and impersonal as possible. There was no small talk and no discussion of his problems. Through this approach the patient's resistance to training was overcome. He later reported that such an approach reassured him because he believed that the therapists "meant business" and it "gave me hope."

Both patients were suffering from similar physical diseases and showed similar overt psychological symptoms. These latter were characterized by depression and helplessness. However in one patient the psychological symptoms were part of a chronic neurosis and in the other patient they were a reaction to the disability in a (previously) psychologically healthy person. The successful treatment was very different for each patient. With the one, the therapist has to be very friendly, close and personal; with the other businesslike, distant and impersonal.

It is true that the cases selected for this paper represent the most successful and dramatic achievements of the psychologist-therapist team. Some cases showed only partial success and others none at all. However the cases do illustrate the potentiality of this team. Without the team several of the patients would have become custodial and, most probably, none would have shown the dramatic progress in therapy that has been reported.

The functioning of the psychologist-therapist team may be summarized by the following general outline:

1. The therapist first notes that a patient is not making the expected progress in rehabilitation. He

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ART IN THERAPY: AN OUTLINE OF SUGGESTED PROCEDURES*

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Literature pertaining to art in therapy is not plentiful. Much of what is written on this subject stresses a point of view seemingly esoteric and addressed to a relatively small group. Emphasis in these writings is centered on analytical and diagnostic techniques as applied to the art production.

It is true that this aspect occupies a justifiably important area in treatment procedures, but it is equally true that the sole function of art as a therapeutic medium is not centered in this area.

Art in therapy, upon closer scrutiny, is perceived to be what may be considered a basic premise of occupational therapy: the maintenance of the highest standards of form, color and aesthetic principles. These are unquestionable ramifications of valid, clinical occupational therapy and, dependent upon orientation of the therapist and skill in treatment techniques, these properties become curative and remedial.

In offering the patient any substitute for the above we appreciably reduce the value of the total therapeutic situation. Art in terms of therapy, by adherence to the previously mentioned principles, becomes applicable to most aspects of occupational therapy activity.

The pliability and wide range of art forms provide for the therapist an extremely variable basis for instituting the patient-therapist relationship. From the first crayoned efforts of the newcomer to the skillfully rendered production of the more dextrous patient there is gratification derived from the creative mechanisms involved combined with the therapist's commendation.

I have found it significant that many patients who are motivated by the art experience do not confine their efforts to this medium indefinitely. They are, as a result of becoming familiar with color, design and their application to many useful objects, enabled to progress to those crafts which possess more dimension. Ceramics, woodcarving, weaving and metal work are but a few of the activities which become more meaningful to the patient because of exploration in the use of free art mediums.

Due to varying circumstances it is sometimes not convenient for the occupational therapist in the field to introduce art into the shop or ward program. Lack of time, heavy patient content, insufficient personnel or limitations of the physical plant are problems which confront the therapist in the process of establishing art activity. Taking these factors into consideration I have compiled the following outline of procedures, constructed to aid the occupational therapist in instituting an art program or reinforcing one that is now functioning. The outline has been primarily constructed to meet the needs of therapists in the neuropsychiatric field but is adaptable to other areas of occupational therapy.

At present I am utilizing this outline as a basic structure for a broadly spaced state hospital program. Included in this program are selected groups: on shock unit service, male and female reception services, continued treatment services, adolescent and children's groups.

At the present writing the outline is proving flexible and amenable to any changes needed to expedite current or planned activity. Future situations and results will, in all probability, call for further revision.

I. Purposes of program organization
   - A. To coordinate theory and practice in formulation of a work plan that is applicable in all aspects to the emotional and intellectual needs of the patient.
     1. To insure a flexibility that will meet requirements, immediate and ultimate, of patient, personnel and environment.
     2. To foster and guide spontaneous expression on the part of the patient.
     3. To encourage gratification and approval through minimization of destructive drives.
        - a. Acceptably expressed aggression.
        - b. Externalization of subconscious material as a channel for the relief of anxiety.
   - B. To aid in developing, or redeveloping, an appreciation of art forms as related to daily activity.
   - C. Establishment of a normal work tolerance and an acceptable attention span which may be transferred to hospital adjustment or post-hospital endeavor.

II. Methods
   - A. Create an atmosphere and environment of ease and informality conducive to relaxation and release of tension.

*Presented at the Occupational Therapy Workshop Conference, Letchworth Village, New York, October 10, 1952.

The writer expresses his appreciation to Lila C. Michael, O.T.R., for constructive criticism and suggestions in preparing this material.

B. Discuss art in relation to the patient's experiences.
   1. Home
   2. School
   3. Specialized training

C. Explore latent talents and skills as possible factors in rehabilitation.

D. There should be a minimum of academic teaching or instructional procedure. In some instances didactic methods will be indicated and in these instances extreme care should be exercised that the instruction at no time exceeds the patient's level of acceptance.
   1. Activity should meet patients' requirements as set forth on physician's prescription.
      a. Grade activity within prescribed level of requirement dependent upon the clinical progress involved.
      b. Regard activity as vital component of total treatment program.
      c. Aimless, unsupervised activity is of no clinical value in a well constructed dynamic treatment program.

III. Aims and objectives

A. Emphasis on appropriateness
   1. Encourage proper selection of materials and implements and emphasize limitations of each.
   2. The goal of the prescribed activity must be well defined by the therapist in order that the patient may have a comprehensive picture of what he can accomplish.
   3. The realistic goal attained is far more rewarding than one out of reach which is never approximated.
   4. The value of simplicity and integrity should be stressed during the course of the activity.

B. Development of aesthetic judgment.
   1. Sound judgments and organized thinking are formed through self-expression and creative endeavor.
   2. Encourage an emotional reaction to art rather than the visual experience alone.
   3. Through proper guidance and suggestion the therapist can aid the patient in gaining the knowledge that art is functional and occupies an important place in integrative and rehabilitative processes.

IV. Attitude of therapist

A. The attitude of the therapist, while objective, should never convey an air of tolerance or resignation.
   1. The result of proper attitudes expressed can culminate in an inter-personal relationship that is both supportive and encouraging offering the patient security and reassurance.
   2. Attitudes should be managed so that their dynamic values assist the patient in accepting reality situations.
   3. The therapist should have a working knowledge of the media involved.
      a. Limitations in relation to the patient's capacities.
      b. Careful consideration that frustrative elements are lessened.
   4. Acceptance of bizarre, fantastic and sometimes unacceptable productions.
      a. Therapist should not analyze, diagnose or prognosticate.
      b. Unusual manifestations should be brought to the attention of the physician.

V. Materials

A. Choice of materials should be based on a preconceived character of the work plan.
   1. Selection of materials should be the result of careful observation of quality and usage in proportion to cost.
   2. Efficient and economical apportionment and employment of supplies reinforce the structure of the program.

VI. Summarization

A. The suggestions for an art therapy program as outlined here are in no respect a set of inflexible rules that preclude deviation. They are designed to meet the immediate needs of the therapist and, dependent upon patient problem and situation, can be amended to most aspects of this adjunctive therapy.

B. The program differs mainly in one respect from the conventional art class curriculum. The activity prescribed is a therapeutic measure and each aspect should be prescribed for its curative value.

C. Environment and attitude are stressed with the goal in view that we are endeavoring to reconstruct and reintegrate personality structures, rather than to produce fine artists.
   1. Patient can gain release of tension on sublimatory level.
   2. Patient is able to project emotional material in form of symbolic representation as a method of abreaction.
   3. Patient can gain or regain good work habits, decrease asocial tendencies and attain satisfaction as a result of commendation given for his efforts, factors which are of considerably more value than a flawless product.

NATIONALLY SPEAKING

From the President

The Secretary of the Navy invited fourteen women to participate in an information cruise to Pearl Harbor. Your president represented occupational therapy in this group. It was an informative and most delightful experience. The trip was lightly dubbed "Operation Petticoat," but its purpose was serious. It was to inform civilians of the Navy's current program in relation to the international situation.

The trip out was spent on the hospital ship *Repose* which was returning to duty as a floating hospital in Korea. We were the immediate guests of hospital staff and ship's officers and crew. No patients were abroad as the ship was going out to replace her sister ship, the *Haven.*

The full 750-bed hospital is trimly fitted into a hull originally designed as a freighter. Operating rooms, X-ray equipment and all the technical requirements were there ready to take on the serious job of caring for the wounded. Under the command of Captain A. M. Ecklund, the ship was staffed with medical officers, specialists in the usual range of hospital departments. Heaviest emphasis was of course on surgery.

An opportunity to see every detail of the hospital and discuss the program with its medical and nursing staff gave a picture of the fine planning and intensity of the program. Colored slides taken while the hospital was in full operation brought the program more clearly to life. Patients are brought in from the forward areas of combat by helicopter and are cared for on board within half an hour after being injured. The average lapse of time is forty-five to ninety minutes. The organization apparent in the helicopter drill we witnessed can only suggest the precision with which so specialized a hospital operates.

It was disappointing to encounter a very limited concept of occupational therapy. Many of the young physicians had spent the major portion of their medical experience in the Navy and knew occupational therapy only as a "diversion." The work aboard was predominantly surgical and early activity was advocated. The average length of hospitalization was two weeks. Psychiatric cases, though in smaller numbers, were regularly found among the case load. Some staff doctors agreed that a well-directed occupational therapy program could be of marked therapeutic value. It would be of service, however, only with direct working contact between the occupational therapist and the patient. The service required could not be given adequately if administered through hospital corpsmen unless they were fully qualified occupational therapists. The corpsman aboard who had "some craft training" as an occupational therapist was not used as such and felt there was no place "for that kind of work" aboard a hospital ship.

It is important to mention, however, how frequently and warmly the medical and nursing staff referred to their corpsmen as dependable and indispensable. A group of selected, trained, enlisted personnel carry out the nursing care of the patients under the direction of a registered nurse. Though a satisfactory procedure in nursing, where the care is predominantly physical, it would not likely allow the subtleties of interpersonal relationship so important as a therapeutic medium in an occupational therapy program.

And of course we had to "inspect" the ship herself. She was beautiful inside and out as her crew put on the final touches for the big inspection scheduled in Pearl Harbor. Later on Admiral Phillips assured us she passed her inspection with special mention. Captain J. M. Wyckoff, the ship's commanding officer, invited us into every department and corner of her operating areas. We saw and heard much about equipment and procedures that left us starry-eyed and impressed. Though we steered her off course, a flip of a lever and Navy know-how brought her right back into line. We were acutely aware of the fine caliber of men which comprised her personnel. Steady and assured, they knew their jobs. They were very courteous but unruffled by the "load of VIPs."

We landed with all the local color of hula dancers, Hawaiian music and welcoming leis. Our host, the Navy, left no stone unturned to fit us comfortably into Navy life. It was simple, compact and efficient. We felt that careful planning had made use of available facilities with a minimum of additional expense. We paid for our own meals and use of linen. This soon allayed our fears that the trip was a very pleasant but extravagant use of taxpayers' money. Being taxpayers ourselves made us money-conscious. We heard economies discussed both directly and indirectly at varying rank levels. Program and equipment however did not seem to be curtailed.

The trip all came into focus in our subsequent briefings. We were there for civilian orientation. Admiral Arthur W. Radford received us in the midst of his busy preparation to take up the responsibilities of his new appointment as Chairman of Joint Chiefs of Staff with headquarters in Washington. We were briefed by top-ranking officers of CinCPAC which is pronounceable and means Commander in Chief, Pacific. This Pacific command, established by the National Security Act of 1947 and placed under the Joint Chiefs of Staff, includes the Army, Navy, Air Force and Marine

elements assigned to the Pacific Theater. It was in this comprehensive point of view we were oriented by hours of briefing throughout the week.

The presentations included the history of the Korean situation and its current state in relation to world conflicts today. It covered personnel: its selection, training, numbers and current location. It covered "logistics" (the wrapper for equipment and supplies): materiel vital to the effective procedure of the personnel. It included the enemy: what we know about him, why he fights, where he fights and how. It presented the present situation and the anticipated future. Facts and figures were laid before us. We were asked to forget details, as they were classified information, but retain a concept to bring home with us for open discussion. Figures are never so safe as when they are left with the ladies who misquote and forget. A concept is widely spread however as ladies talk.

Of special interest to us was the medical program. Our group was hospital-oriented. It included national representatives of the para medical services, national defense, education and public relations.* We were impressed with the quality of personnel and the comprehensive pattern generally provided to maintain health, prevent injury and provide care for military casualties. The interworking relationship of Navy, Army and Air Corps personnel was evident at Tripler General Hospital and the Air evacuation service of Korean casualties at Hickam Field where Air Corps planes, staffed with Navy nurses, transported wounded soldiers and marines of the United States and other United Nations. The Fleet Marine Force has developed such special equipment as the armored vest, iron pants and thermal boots now used by all services. The Navy hospital ships anchor in the bay of forward areas caring for casualties of all military services. Of course each service feels a healthy pride in its own contribution but works together for a job to be done.

To illustrate the briefings, we observed programs and special demonstrations at the Army's Schofield Barracks, the last outpost for combat training, technical training schools, and home base for some of the divisions now in Korea; the Navy's Ammunition Depot, Pacific Radio station, Air Base (with flight around the island), Submarine Service (with an underwater cruise and lunch aboard), the Marine Base with a graphic though grim demonstration of air-ground task force in coordinated procedures.

In this busy week there was little time left to see much of the beautiful Hawaiian Islands and our personal friends there. However, we did relax at the Officers' Club at Kailua and Waikiki Beaches. I enjoyed having dinner with the Hawaiian Occupational Therapy Association and talking with the group at the invitation of their president, Esther Pyun Castle. I also found time for a delightful Hawaiian picnic with Milwaukee-Downer College occupational therapy alumnae.

We were in the capable and hospitable hands of the Navy. From the Admiral's "At Home" through the informal ship's party before the *Repose* left Pearl Harbor, to the casual chit-chat with officers and enlisted personnel in their respective messhalls as we dined, we learned a lot. We met and talked with personnel of all services including the wounded evacuees from Korea. We heard the gripes and discontentment as well as the assurance and convictions of the men of all ranks. We could not help compiling a concept to bring back home; it is grim but realistic.

The concept is essentially this: we live today in a world of conflicting ideologies and technical proficiencies. If we believe in our way of life we must fight for it. We have in the Pacific a skillful coordinated strong arm of service. To do its job it must be supported and acknowledged at home. Americans are not a war-minded public. We look forward to an armistice and cessation of hostilities. Let us not limit our vision however. Korea is a small incident in a large pattern of world controversy. Strength, well guided and well supported, is our assurance of a living philosophy wherein the importance and dignity of the individual is recognized. Let us be informed; let us think through the issues; and let us be proud of the effort and skill that builds a military organization on recognition of the individual. The careful training and medical programs we saw support this philosophy. In a later issue let us discuss the relation of all this to occupational therapy.

Henrietta McNary,
President.

*Guests of the Navy trip: Mrs. R. Max Brooks, head of Women's Defense Advisory Council of Austin, Tex.; Mrs. Margaret Wiley Carr, member of auxiliary board of Children's Memorial Hospital, Chicago; Miss Lena Cecile Clauve, dean of women, University of New Mexico; Mrs. Elliott Donnelly, member of auxiliary board, Children's Memorial Hospital, Chicago; Miss Dorothy Louise Gebauer, dean of women, University of Texas; Miss Beulah Adeline Hunzicker, president of American Dietetic Assn., (Presbyterian Hospital, Chicago); Mrs. Lorene Whitman Ingalls, past president of women's board, Presbyterian Hospital, Chicago; Miss Mildred Irene Lorentz, director of department of nursing, Michael Reese Hospital, Chicago; Dr. Minnie L. Maffett, physician, Dallas, Texas; Miss Henrietta McNary, president, AOTA; Miss Elizabeth S. Moran, director of nursing, Henry Ford Hospital, Detroit; Miss Mary E. Nesbitt, vice-president of APTA, (supervising physical therapist, Massachusetts General Hospital, Boston); Mrs. George A. Ranney, Jr., member of the board of Chicago Lying-In Hospital; Miss Betty Ross, producer of educational programs, National Broadcasting Company, Chicago; Lt. Cdr. Kathleen Ziegler, USN, assistant military training officer, Ninth Naval District, Great Lakes, Ill.

From the Executive Director

The National Rehabilitation Association convened a rehabilitation conference in Atlantic City, April 27, 28, 1953, to which all the national voluntary organizations concerned with rehabilitation were invited to send one or two representatives. Your executive director represented the AOTA. This was the first such effort since about 1943 when the National Rehabilitation Council was formed and lived a relatively short life. The NRA is to be commended for the initiative they exhibited in bringing together the increased number of health agencies which demonstrate the rehabilitation picture today.

The National Rehabilitation Association was the logical agency to call this conference as it is the oldest rehabilitation organization, having been originally sponsored by the federal Office of Vocational Rehabilitation. This organization, which has operated for many years as a voluntary agency with headquarters in Washington, D.C., enjoys a membership of some 14,000 persons, the majority of whom are rehabilitation counselors in state and federal services. In recent years, however, emphasis has been placed on a broader membership with a resulting representation of all rehabilitation personnel, individual and organizational. Included in the stated objectives of this organization are: (a) provision through conferences on a national, regional and local level for discussion of all problems relating to rehabilitation of the handicapped, (b) encouraging team work in rehabilitation through maximum use of knowledge and skills of all professions. The NRA is not to be confused with the two newly organized associations which are limited primarily to the Veterans Administration, namely, the American Association for Rehabilitation Therapists (manual arts and educational therapy) and the Association for Physical and Mental Rehabilitation (corrective therapy).

Much of the following material will impress you as reiteration and re-hash of the same old thing—it is! But, the important thing was the opportunity afforded for promoting inter-agency acquaintance, opportunity to appreciate at first hand what others are doing, to verbalize likenesses and differences. All of which points to the knowledge that rehabilitation today is not conducted by a select few, but by many with a common understanding and blending among the agencies involved. I find this conference difficult to describe to you as no attempt was made to reach solutions or decisions—it was all informal give and take. Rather it is the underlying idea behind the conference and what was on the minds of the leaders present which I will try to convey to you.

The *purpose* of the Atlantic City conference was:

To survey voluntary and public programs directed toward the rehabilitation of the handicapped in the light of established need for rehabilitation services.

To determine what common goals exist among organizations represented at the conference with respect to the rehabilitation of the handicapped.

To plan for more effective cooperation among organizations represented to advance the goals they find themselves to hold in common.

The *scope* of the conference was defined by a description of rehabilitation as "services directed toward helping physically and mentally impaired persons of all ages attain the highest possible degree of competency." Since it was impossible for the conference to consider with any degree of effectiveness the broader objectives of many of the organizations represented, it was considered desirable to limit discussion to the above definition of rehabilitation. Participants were urged to keep a horizontal and not a vertical thread throughout, and to assume broad lines of discussion avoiding generalized philosophy and the detailed problems of special disability groups.

Participation in the conference included approximately thirty-seven organizations, totaling 55 persons. A listing should prove interesting to the reader as it depicts the cross-section of new and older agencies comprising the field today.

American Association of Mental Deficiency, Inc.
American Association of Medical Social Workers
American Association of Rehabilitation Therapists
American Association of Workers for the Blind
American Cancer Society, Inc.
American Diabetes Association, Inc.
American Federation of the Physically Handicapped, Inc.
American Foundation for the Blind
American Hearing Society
American Heart Association
American Neurological Association
American Occupational Therapy Association
American Physical Therapy Association
American Rheumatism Association
Association for Physical and Mental Rehabilitation
Blinded Veterans Association
Bureau of Employment Security
Commission on Chronic Illness
Council on Physical Medicine and Rehabilitation
Disabled American Veterans
Division of Health Services
Goodwill Industries of America, Inc.
International Council for Exceptional Children
International Society for the Welfare of Cripples
National Association for Mental Health, Inc.
National Epilepsy League, Inc.
National Federation of the Blind
National Foundation of Infantile Paralysis
National Multiple Sclerosis Society, Inc.
National Paraplegia Foundation
National Rehabilitation Association
National Society for Crippled Children and Adults, Inc.
National Tuberculosis Association
Office of Vocational Rehabilitation

Orthopedic Limb Manufacturers Association
United Cerebral Palsy Association
United Mine Workers Welfare and Retirement Fund
Veterans Administration

The *plan of the meeting* was unique in that no agenda was prepared in advance. Participants built the agenda by deciding what problems they wanted to discuss. The 6-6 group method was employed, as well as dividing the assembly into four small work groups. The four work groups were led by representatives invited in advance to serve as leaders (Mildred Elson, American Physical Therapy Association; Jayne Shover, National Society for Crippled Children and Adults; Mr. Glenn Jackson, Orthopedic Appliance and Limb Manufacturers Association; Marjorie Fish, AOTA). The groups were informed of each other's activities by summary reporting sessions and a final evaluation.

Topics of discussion for the agenda, suggested by participants, revealed a trend of thinking which is significant enough to record here: mechanics of cooperation; coordination of effort and need of an over-all organization to integrate interests; exchange of personnel for conference programs; tax supported programs; standards of public media and ethics of educating the public; recognition of common and non-common objectives; the "lag" representing the difference between those in need of, and those actually rehabilitated each year; placement of physically handicapped; selective training methods; personnel shortages; standards for professional education; financial needs—scholarships, fellowships, program support; incidence of better statistics; legislation—translation of objectives for handicapped into political action (local, state, federal); research re methods and techniques.

Out of the above, four main topics were crystallized for the final agenda—finances, personnel, facilities, legislation. Once agreed upon, the groups went to work. These four small work groups were assembled by the 1 - 2 - 3 - 4 "count off" method so each group was well mixed from the standpoint of organization and field representation. It was agreed that each group would attack these themes through discussion in answer to the following questions:

1. What kind of program do we want to promote? Services, etc.
2. How do we get public support and acceptance to these programs?
3. What are the "road blocks" to adequate programs and how do we overcome them?
4. What can we do together to advance the rehabilitation effort to get more trained personnel, better facilities and utilization of existing and expanded services, better financial support?
5. What evaluation do you give to this conference?

Summary of the discussions, conference evaluation and recommendations growing out of the conference of value to us are as follows:

There is a lack of know-how among agencies and in the field.

There is evidence of limited professional perspective. Staff members should be better informed.

There is a need for comprehensive rehabilitation services and a study of methods by which resources of voluntary agencies can be used to coordinate services.

There is too much segmenting and fragmentalizing of the various services and therapies i.e. physical, occupational, recreational, music, educational, manual arts, corrective, etc. This constant "splintering" complicates the effectiveness of service rendered, recruitment efforts and placement of personnel. There should be reasonable consolidation.

Agencies, both national and state, should have a year round educational program and not just delve into sporadic public expression of their program.

Two of the most interesting recommendations were: (1) There is no need for an over-all organization or rehabilitation council. Members of the conference expressed no interest in another formal organization, but recommended provision for a format to enable people to get together periodically (similar to this conference). (2) Publication of a directory of agencies and organizations concerned with the handicapped, giving their functions, activities, and contributions to the field.

In conclusion I would like to say that I think we all returned to our respective posts with some new ideas and a certain amount of direction from which our membership will benefit through the year. You will realize this report has given you few specifics. You can secure further information from (1) the digest of the conference to be prepared by the NRA from reports submitted by the group leaders. We will notify you when this is ready and make it available through the AOTA loan bookshelf. (2) Compiled reports on each agency participating in the conference (available from AOTA loan bookshelf). This identifies the organization and would be excellent reading for members who want clarification on the bewildering number of old and new organizations claiming entry into the world of rehabilitation. (3) Task force report of the President's committee on the physically handicapped available from AOTA loan bookshelf.

MARORIE FISH, O.T.R
Executive Director.

From the Assistant to the Executive Director

The second annual conference of Region II of the National Rehabilitation Association was held May 3 - 6 in Atlantic City. All personnel (official and voluntary) working with the physically handicapped in Delaware, New Jersey, New York and Pennsylvania were invited to attend. Representatives of the following professional groups were among those present: physicians, administrators, vocational rehabilitation counselors, occupational therapists, physical therapists, speech therapists, medical social workers, psychologists.

"Mobilization of Community Resources for the Handicapped" was the topic of this three day conference. Cooperation of all agencies and the pooling of all resources were stressed as means to improve the efficient functioning of vocational rehabilitation agencies and counselors. The interest in such cooperation was apparent from the excellent participation by all present in the sessions throughout the meeting.

One full day was devoted to "Disability, Rehabilitation and Public Assistance" (vocational rehabilitation of severely disabled public assistance recipients including the blind). Representatives of the Federal Security Agency and the Federal Office of Vocational Rehabilitation were interviewed on the aims and provisions of the state-federal program of public assistance for aid to the permanently and totally disabled and for vocational rehabilitation. A discussion of what is involved in achieving total rehabilitation brought out the question: "What is total rehabilitation?" A demonstration of the case review team method was given by a medical consultant, medical social worker and vocational rehabilitation counselor. Following this session there was audience discussion of the techniques and community resources used by workers in the solving of clients' problems.

The services of rehabilitation centers and workshops were the concern of the second session of the conference. There were no set speeches, however authorities in various fields were responsible for answering such questions as: How does the rehabilitation counselor prepare the client for rehabilitation center services? How does the agency counselor participate in the rehabilitation center program for the development of the client's post-center plans? How does the rehabilitation center staff develop a program to meet the patient's total needs? (Two O.T.R.'s were the speakers on this question.) How does the rehabilitation center staff coordinate with the referral agency counselor for social vocational planning and patient follow-up? Whom does a workshop serve? How is it developed? What types of work are available? What about auxiliary services? How does the community help? What about state and federal participation? What is the counselor's part?

Representatives of several New York City agencies (public and private) have been meeting regularly during the past year to discuss common problems. Their regular monthly meeting was conducted as a demonstration and interpretation of the functions of a placement inter-agency council, the final session of the conference. This demonstration of coordination of placement efforts showed how it is possible for all agencies interested in the welfare of the disabled to cooperate with each other informally in solving their common problems.

The participation of representatives from many varied agencies concerned with the rehabilitation of the physically handicapped aided in the presentation of a broad program of vital interest. "Rehabilitation Around the World" was the appropriate topic of the closing speech by Henry H. Kessler, M.D., Director of the Kessler Institute, member of the New Jersey Rehabilitation Commission and Board Fellow of the AOTA.

Inquiries concerning recordings of this conference should be addressed to the President of Region II, National Rehabilitation Association, John J. Jennings, Jr., New Jersey Tuberculosis League, 15 East Kinney Street, Newark, N.J.

Mary Frances Heermans, O.T.R.,
Assistant to the Executive Director.

From the Educational Secretary

In the March-April issue of AJOT (Vol. VII, No. 2, 1953) the first list of those who successfully passed the American Occupational Therapy Association registration examination was published. As indicated at that time, the February, 1953, examinees would be included in this issue. They are as follows:

Ager, Charlene L., 12
Agostini, Lynette T., 16
Alwin, Joyce M., 17
Amison, Alice S., 20
Andrea, Virginia, 10
Barber, Lois M., 18
Barnard, Edith R., 2
Bean, Florence E., 11
Beaudoin, Rita Mae, 4
Begier, Jacqueline R., 2
Bell, Barbara Joan, 5
Bellatty, Barbara A., 11
Benner, Audrey, 6
Bettis, Teresa E., 12
Board, Gwindolyn, 16
Boggs, Grace R., 16
Bond, Faye E., 5
Bondy, Joanne, 26
Bonness, Mary M., 10
Borland, Dolores, 26
Bowden, Janice, 20
Bowen, Mary E. P., 16
Brnak, John J., 22
Brooker, Barbara A., 8
Brothers, Barbara J., 3
Brown, Sadie B., 12
Brummel, Lorraine*, 23
Brunsell, Carol, 23
Buckingham, Mary L., 16
Buckley, Grace L., 20
Bullock, John, 26
Bunker, Nancy L., 4
Buditt, Chester D., 16
Burkhardt, Kerby L., 24
Burton, Christine V.*, 16
Bushey, Marie A., 17
Butz, Clyde W., 13
Callan, Mary Jo, 20
Cantwell, Jay, 7
Carleton, Jane A., 19
Chandler, Virginia L., 20
Charles, Evelyn, 4

Chew, Nancy H., 2
Chipser, Joseph F., 16
Christensen, Nola, 18
Cohen, Josephine, 14
Cohen, Ruth R., 2
Coley, Ida Lou, 18
Cooke, Dagney M., 19
Crissman, Martha E., 19
Crone, Dolores, 2
Cummins, Mary F., 10
Curran, Patricia A., 3
Deffley, Eleanor, 3
Delario, Barbara, 2
Deutsch, Hermine, 2
Dieterich, Dolores E., 25
Dinneen, Diane, 19
Disparti, Genevieve, 16
Donley, Florence P., 4
Doolittle, Joyce B., 11
Dovich, Jr., George, 16
Drake, Ruth M., 11
Dumond, Marion J., 4
DuPont, James F., 11
Eastman, Dorothy, 11
Edgar, Janet, 23
Egan, Emily Ann, 120
Emerton, Eve, 16
Ervin, Jean, 2
Farragher, Arden S., 23
Fiala, Catherine V., 13
Feblowicz, Ruth, 19
Feldman, Jewel E., 3
Foote, Carol P., 2
Forsyth, Edith M., 7
Frederick, Mary C., 16
Freeland, Janet, 10
Fullbright, Mary Jo, 5
Gaylor, Gwendolyn, 2
Gervais, Rosalie, 120
Gillis, James, 26
Goldberg, Norma, 12
Green, Joycelyn F., 3
Guerrero, Maria E., 17
Gully, Rita C., 17
Hagele, Francine, 10
Hall, Irma N., 7
Hamilton, Edith, 164
Hammer, Kathryn C., 10
Harkins, Neva J., 18
Harris, Helen J., 20
Hart, Patricia A., 20
Heineken, Mary A., 3
Henning, Nancy S., 8
Hitt, Helen C., 4
Hogan, Jeanne M., 10
Holland, Martha G., 16
Houman, Phyllis M., 4
Hovorka, Mary J., 17
Howe, Jo Ann, 5
Howland, Charlotte L., 23
Hungerford, Barbara S., 6
Izard, Ethel M., 15
Jablonicky, Margaret, 10
Jacobs, Barbara E., 2
Janes, Martha F., 8
Jensen, Virginia A., 16
Jepkema, Audrey, 4
Johnson, Margaret A., 16
Johnson, Marilyn B., 15
Johnston, Mary A., 16
Kaiser, Constance C., 13
Karr, Donna L., 5
Keith, Jean L., 2
Keough, Donna F., 4
Kepler, Marcia, 9
Knoll, Joanne M., 5
Kodani, Lucy, 26
Koehler, Nancy, 17
Kohlmetz, Carol C., 10
Lalewicz, Virginia L., 4
Lapidakis, John 19
Lascelle, Katherine E.*, 2
Leete, Mary F., 16
Leon, Judith B., 20
Lessard, Patricia, 17
Lietaert, Rowena, 20
Lockwood, Cherry L., 18
Lotts, Jean R., 18
Lucci, Jennie A., 4
Marquis, Jeanne M., 16
Martin, Margaret E., 5
Martinez, Betsy H., 6
McCarthy, Margaret M., 17
McCarthy, Mary J., 4
McCasland, Frances A., 20
McDonald, Lucie J., 16
McGaughey, Joan E., 8
McGlaun, Joy E., 20
McKoen, Marjorie, 10
McVay, Mary R., 5
Mefford, Gayle I., 4
Minamide, Helen C., 18
Moore, Camille A., 3
Mueller, Martha, 24
Mulder, Joan M., 4
Murase, Kimi, 12
Nast, Robert W., 2
Nealon, Nancy L., 10
Nelson, Ruth V., 4
Newman, Lois, 4
Okamoto, Audrey C., 18
Oltmann, Leona R. E., 12
Omori, Dorothy K., 3
Otis, Joan L., 3
Owen, Jack W., 4
Pahner, Marietta L., 19
Parke, Marilyn J., 3
Pavlovich, Helen, 2
Petterson, Constance I., 5
Plummer, Suzanne K., 5
Pottenger, Betty J., 22
Prescott, Carol J., 12
Prince, Irene L., 19
Prudich, Charlotte A., 16
Ramsay, Irene, 3
Rathling, Elisabeth M., 3
Redmond, Merton A., 22
Rennaker, Barbara B., 3
Rice, Madeleine N., 2
Richter, Mary H. C., 5
Riley, Geraldine, 23
Ringstrom, Barbara, 9
Robinson, Ann E., 5
Rockowitz, Anne F., 2
Rodert, Elizabeth E., 18
Rodriguez-Arte, Sylvia, 12
Roell, Leslie L., 4
Rothwell, Helen S., 18
Rudolph, Joan M., 17
Rundell, Eve, 5
Rutowski, Helen M., 26
Salls, Arnold B., 16
Sanzenbach, Nancy J., 9
Schindler, Jeannine C., 5
Shalik, Harold, 2
Shames, Margaret, 26
Shebanek, Marian L., 13
Shurpit, Joyce A., 10
Silberzahn, Mary A., 10
Smink, Suzanne, 4
Smith, Yvonne, 4
Sokolow, Norman J., 12
Sommer, Denise, 13
Sorensen, Carla J., 24
Starke, Cary, 20
Starvaggi, Francis, 12
Talmage, Mary E., 14
Tanigaki, Irene S., 12
Tarkan, Florence J., 19
Thureson, Loretta D., 18
Trautman, Marianne, 24
Vess, Mary L., 5
Wachter, Lucie, 2
Wearne, Richard W., 19
Webb, Ruby J., 5
Wegner, Rita C., 3
Weems, David A., 16
Weir, Lois E., 120
Weiselberg, Marilyn, 3
Weisbrod, Ruby E., 12
Wells, Richard F., 13
Werner, Julie, 19
Whipple, Ruth J., 4
Wilson, Eleanor, 2
Wilson, Wanda F., 20
Wood, Elizabeth J., 20
Worden, W. Joan, 4
Wyatt, Ruth Ann, 16
Yang, Iris, 2
Yang, Ming-Geh, 19
Yerxa, Elizabeth J.*, 19
Yoakum, Mary E.*, 16
Zeiden, Anita A., 13

* *Completed with Honors.*

CODE NUMBERS FOR OCCUPATIONAL THERAPY SCHOOLS

Boston School of Occupational Therapy, in affiliation with Tufts College 1
Colorado A & M College 24
Columbia University 2
Illinois, University of 3
Iowa, The State University of 25
Kalamazoo School of Occupational Therapy, Western Michigan College of Education 4
Kansas, University of 5
Michigan State Normal College 6
Mills College 7
Milwaukee-Downer College 8
Minnesota, University of 9
Mount Mary College 10
New Hampshire, University of 11
New York University 12
Ohio State University 13
Philadelphia School of Occupational Therapy, University of Pennsylvania, School of Auxiliary Medical Services 14
Puget Sound, College of 15
Richmond Professional Institute of the College of William and Mary 16
St. Catherine, College of 17
San Jose State College 18
Southern California, University of 19
Texas State College for Women 20
Washington University 22
Wayne University 26
Wisconsin, University of 23

FOREIGN SCHOOLS OF OCCUPATIONAL THERAPY

University of Toronto, Canada 120
The O. T. Centre and Training School, London, England 164

Martha E. Matthews, O.T.R.,
Educational Secretary.

EDITORIAL

TERMINOLOGY

It is of interest to review the various names that have been, and are being applied, to the practice of using occupations for their remedial value.

While such use had an early origin, if we are to believe the records of ancient Egypt and Greece, we seem to be uncertain if a specific name was given by either nation to the procedure. Also it seems that it was only given to patients suffering from nervous or mental disorders.

As yet, no records seem to be known indicating there was a continuance of such treatment during the Middle Ages, and it may have been in abeyance until the late 18th or early 19th century when the practice became more general because of the advocacy of Pinel, Peil, Rush and others. Apparently none of these worthies coined descriptive terms for the practice although study of the records of the early days of American psychiatry show that such terms as *labor, work cure,* and *moral treatment* had their advocates.

In 1914 Dr. Eva Charlotte Reid suggested the word *ergotherapy* but apparently this term did not meet with much approbation and it never came into general use. About the same time George Edward Barton originated the term *occupational therapy* which has become popular and has received many subdivisions, such as, music therapy, book or bibliotherapy and others—all conveniently indicating a special from of occupation to be used in helping sick persons get well.

More recently the American Psychiatric Association, while keeping the name of its committee on occupational therapy, has also created a committee on cooperation with leisure time agencies which may have been intended to emphasize mental hygiene rather than psychotherapy.

Still more recently Dr. William B. Terhune, in a brochure giving the addresses delivered at the dedication of a building devoted to the application of occupational therapy, has titled this pamphlet *Avocational Therapy.* However it is noticed that the majority of the speakers on this occasion did not use that term and spoke of *occupational therapy.*

While the term occupational therapy has been subjected to criticism occasionally, its broad inclusiveness makes it especially valuable and it is hoped it may continue to be used for the practice of using occupations, no matter of what nature, for their remedial value.

The words "leisure time" and "avocational" seem to suggest connotations as *hobbies* which undoubtedly have value as forms of mental hygiene, but do not so well suggest the remedial value as does the term occupational therapy.

William Rush Dunton, Jr., M.D.

THERAPIST-PSYCHOLOGIST

(*Continued from page* 168)

has observed the behavior of the patient both on the ward and in the retraining situation. He is aware of the general manifestations of the problem (i.e., fear of crutch walking, lack of motivation).

2. The psychologist examines the patients through interview, psychological tests and case history. He formulates a general picture of his basic personality and his primary motivations and attitudes.

3. The therapist and the psychologist must now get together and combine their knowledge of the patient. The purpose of this conference is to understand what the patient is really doing in the rehabilitation situation (i.e., manipulating the therapist) and what the therapy situation means to him (i.e., taking away the comfort of his neurotic helplessness).

4. With the understanding that has been gained, a plan of therapy can be formulated. This may be based on such factors as demonstrating to the patient that his fears are groundless or in preventing the destructive nature of his neurotic tendencies from influencing progress in therapy. A general goal for the psychological aspect of therapy can be formulated along with specific methods of attaining this through modification of the patient-therapist relationship.

5. It is the therapist who carries out these plans. Periodic team conferences are important to evaluate the relationship and perhaps to bring about further modification.

Summary: Psychological factors often play a fundamental role in the rehabilitation process. The relationship between the patient and the therapist is the major tool for handling the psychological problems that arise. The type of relationship optimal for a given patient can be formulated by the therapist and the psychologist working as a team. Several cases illustrating the manner in which this team functions and its potentialities are presented.

Johnson's paste wax rubbed on the base of a glazed ceramic project makes it possible to place the project directly on the floor of a kiln which has been painted with kiln wash. This method is especially good for figurines and projects that have bases difficult to place on stilts. It also avoids the common hazard of stilts adhering to glaze which, in some instances, ruins the project. This method cuts the time used in stacking a kiln almost by half.

1st Lt. Margaret M. McDonald, O.T.R.

ANNUAL CONFERENCE A.O.T.A.

NOVEMBER 13-20 1953
HOUSTON TEXAS
THE SHAMROCK

THEME
REFINING OUR RESOURCES

Conference Chairman
Lucile L. Lacy, O.T.R.
Veterans Administration Hospital
Houston, Texas
Institute Chairman
Fanny B. Vanderkooi, O.T.R.
Texas State College for Women
Denton, Texas
Program Chairman
Mary Britton, O.T.R.
Baylor University College of Medicine
Houston, Texas

PRELIMINARY PROGRAM

SPECIAL NOTICE
Note change in sequence
Institute PRECEDES the General Program

Pre-Conference Meetings

Friday, November 13

Education Committee, Joint Meeting.. 7:30 p.m.-10:00 p.m.

Saturday, November 14

Registration ..... 9:00 a.m.- 5:00 p.m.
Education Committees
Sub-Committee,Schools and Curriculum ..... 9:00 a.m.-12:00 m.
Sub-Committee, Clinical Training.. 9:00 a.m.-12:00 m.
Education Committee, Joint Meeting.. 2:00 p.m.- 6:00 p.m.
Education Committee, Joint Meeting.. 7:30 p.m.-10:00 p.m.
Recruitment and Publicity ..... 7:30 p.m.-10:00 p.m.
Legislative and Civil Service Committee ..... 7:30 p.m.-10:00 p.m.
Special Studies Committee ..... 7:30 p.m.-10:00 p.m.

Sunday, November 15

Registration ..... 9:00 a.m.- 5:00 p.m.
Permanent Conference .....10:00 a.m.-12:00 m.
House of Delegates ..... 9:00 a.m.-12:00 m.
House of Delegates ..... 2:00 p.m.- 5:00 p.m.
Registration Committee, Open Meeting ..... 2:00 p.m.- 5:00 p.m.
Tea Hosts: T.O.T.A. ..... 5:00 p.m.
Registration ..... 7:30 p.m.-10:00 p.m.
Educational Committee Central ..... 8:30 p.m.-10:00 p.m.
Psychiatric Committee ..... 8:30 p.m.
Tuberculosis Occupational Therapists ..... 8:30 p.m.
G. M. & S. Occupational Therapists.. 8:30 p.m.

Monday, November 16

Commercial Exhibits ..... 1:00 p.m.- 5:00 p.m.
Educational Exhibits ..... 8:30 a.m.- 5:00 p.m.
Registration ..... 8:30 a.m.- 5:00 p.m.
Board of Management Meeting ..... 9:00 a.m.-12:00 m.
Board of Management Meeting ..... 2:00 p.m.- 5:00 p.m.

Pre-Conference Institute

Theme
RESEARCH IN OCCUPATIONAL THERAPY

Monday, November 16

Morning Session ..... 9:00 a.m.-12:00 m.
Moderator: Dr. Robert Sutherland, Director, Hogg Foundation for Mental Hygiene, University of Texas, Austin, Texas.
Address of Welcome: Mrs. Fanny B. Vanderkooi, O.T.R., Chairman, Institute Committee.
What Is Research? Dr. Bradford Hudson, Department of Psychology, Rice Institute, Houston, Texas.

The Present Status of Research in Occupational Therapy: Dr. Wells Goodrich, Research Grants and Fellowships Branch, National Institute of Mental Health, Bethesda, Maryland.

Areas in Occupational Therapy That Need to Be Explored by Research: Miss Patricia Exton, O.T.R., Director of Adjunctive Therapies, Menninger Foundation, Topeka, Kansas.

Dr. Robert Blake, Associate Professor, Psychology Department, University of Texas, Austin, Texas.

Coffee

Evaluation of Suggested Research Topics

Moderator: Dr. Ben L. Boynton, Professor of Physical Medicine, Baylor University College of Medicine, Houston, Texas

Panel: Dr. Murray Richards, Member of Research Team on Nutrition, Texas State College for Women, Denton, Texas

Dr. H. N. Peters, Clinical Psychologist, Veterans Administration Hospital, North Little Rock, Arkansas

Dr. H. Rohrer, Director of Urban Life Institute, Tulane University, New Orleans, Louisiana

Miss Sydell Braverman, Supervisor of Research, Woodrow Wilson Rehabilitation Center, Fishersville, Virginia

Dr. Wells Goodrich

Dr. Bradford Hudson

Occupational Therapist

Afternoon Session ..... 1:30 p.m.- 5:00 p.m.

Research Clinic: *Analysis of Selected Current Research Projects*

Moderator: Miss Beatrice Wade, O.T.R., Director, School of Occupational Therapy, University of Illinois, Chicago, Illinois

Panel: As above

Evening Session ..... 7:30 p.m.-10:00 p.m.

Research Clinic: *Evaluation of Selected Current Research Projects (continued) and Summary of Findings*

Moderator: Miss Margaret Gleave, O.T.R., Chairman, Research and Special Studies, American Occupational Therapy Association

Panel: As Above

Questions will be collected

Tuesday, November 17

Registration ..... 8:30 a.m.- 5:00 p.m.
Educational Exhibits ..... 8:30 a.m.- 5:00 p.m.
7:30 p.m.-10:00 p.m.
Commercial Exhibits ..... 9:00 a.m.-12:00 m.
7:30 p.m.-10:00p.m.
Morning Session ..... 9:00 a.m.-12:00 m.

Moderator: Dr. Robert Sutherland

Techniques of Analysis and Interpretation of Data: Dr. Murray Richards

Arranging and Presenting Material: Miss Sydell Braverman

Training for Research: Dr. H. N. Peters and Dr. John H. Rohrer

Questions will be collected

Coffee

Question and Answer Period: Panel as above

Summary and Conclusions: Moderator

General Program

Theme

REFINING OUR RESOURCES

Tuesday, November 16

Afternoon Session ..... 1:30 p.m.- 5:30 p.m.

Moderator: Mrs. Lucile L. Lacy, Conference Chairman

Invocation:

Welcome: Dr. Stanley Olson, Dean, Baylor University College of Medicine

Business Meeting: Presider, Henrietta McNary, O.T.R., President A.O.T.A.

Coffee

Recruitment Workshop

Evening Session

Commercial Exhibits ..... 7:30 p.m.-10:00 p.m.
Educational Exhibits ..... 7:30 p.m.-10:00 p.m.
Special Meetings
Veterans Administration ..... 7:30 p.m.-10:00 p.m.
Army ..... 7:30 p.m.-10:00 p.m.
Air Force ..... 7:30 p.m.-10:00 p.m.
A.J.O.T. Committee ..... 8:30 p.m.-10:00 p.m.
House of Delegates ..... 8:30 p.m.-10:00 p.m.

Wednesday, November 18

Registration ..... 8:30 p.m. - 5:00 p.m.
Commercial Exhibits ..... 9:00 a.m. - 5:00 p.m.
Educational Exhibits ..... 9:00 a. m.- 5:00 p.m.
Morning Session ..... 9:00 a.m.-12:00 m.

Moderator: Mrs. Winifred C. Kahmann, O.T.R., Director of O.T. and P.T., Indiana University Medical Center, Indianapolis, Indiana

Keynote Speech: Dr. Ben L. Boynton, Professor of Physical Medicine, Baylor University College of Medicine, Houston, Texas.

Present Treatment in Tuberculosis: Dr. William S. Schwartz, Chief, Professional Services, V.A. Hospital, Oteen, N. C.

Therapeutic Rehabilitation Following Chest Surgery: Mrs. Frances Alterman, R.P.T., Chief, Physical Therapy, V.A. Hospital, Oteen, N. C.

Miss Charlotte Smith, O.T.R., Chief, Occupational Therapy, V.A. Hospital, Oteen, N. C.

Luncheon: Psychiatric O.T.'s .....12:30-p.m.- 1:30 p.m.
Afternoon Session..... 2:00 p.m.- 5:00 p.m.

Moderator: Lt. Col. Charles D. Shields, Chief, Physical Medicine Service, Brooke Army Hospital, Fort Sam Houston, San Antonio, Texas.

Current Trends in the Treatment of Burns: Representative of Surgical Research Unit, Brooke Army Hospital

Coffee

Training in the Use of Upper Extremity Prostheses: Capt. Mary Berteling, Brooke Army Hospital.

Occupational Therapy for the Aged—Minnesota's Program: Miss Genevieve Cummings, O.T.R., Department of Public Welfare, St. Paul, Minnesota

Evening Session ..... 6:00 p.m.-10:00 p.m.

School Round-up: *Ship's Prizes*

Thursday, November 19

Commercial Exhibits ..... 9:00 a.m.- 5:00 p.m.
Educational Exhibits ..... 9:00 a.m.- 5:00 p.m.
Board Meeting ..... 2:30 p.m.- 5:30 p.m.
Morning Session ..... 9:00 a.m.-12:00 m.

Moderator: Dr. L. P. Restine, Superintendent, Austin State Hospital, Austin, Texas

Group Work Practices—Their Application in O.T.: Dr. Eugene McDanald, Psychiatrist, University of Texas Medical Branch, Galveston, Texas

Coffee

Use of Hospital Resources as Treatment: Miss Louise McMillen, O.T.R., V.A. Hospital, Waco, Texas

Occupational Therapy in Psychiatry—Treatment or Tradition: Mr Laurel V. Nelson, O.T.R., Coordinator, Adjunctive Therapies, Topeka State Hospital, Topeka, Kansas

Afternoon Session ..... 2:00 p.m.- 5:00 p.m.

Moderator: Dr. Oscar O. Selke, Jr., Physiatrist, Hermann Hospital, Houston, Texas

Practical Considerations in the Treatment of Epilepsy: Dr. William S. Fields, Baylor University College of Medicine, Houston, Texas

Coffee

Trends in the Treatment of the Cerebral Palsied: Dr. Margaret Watkins, Dallas, Texas

O.T. in a Resident School for Cerebral Palsied: Miss Dorothy Sniffin, O.T.R., Moody School, Galveston, Texas

Evening Session

Cocktail Party ..... 6:30- 7:30 p.m.

Hosts "The Ship"—The Commercial Exhibitors

Banquet ..... 8:00 p.m.

Have You Tried Listening? Dr. Wesley Wiksell, Louisiana State University, Baton Rouge, Louisiana, and Consultant on Communication in Industry

Friday, November 20

Morning Session ..... 9:00 a.m.-12:00 m.

Moderator: Dr. Warren T. Brown. Professor of Psychiatry, and Chairman of Department of Psychiatry, Neurology and Rehabilitation, Baylor University College of Medicine, Houston, Texas

Problems and Functions of a Respiratory Center: Dr. William A. Spencer and staff, Southwestern Poliomyelitis Respiratory Center, Houston, Texas

Coffee

Visualizing Cells That Repair: Dr. C. M. Pomerat, University of Texas Medical Branch, Galveston, Texas

Interpersonal Relations: Dr. Bernice Moore, Consultant, The Hogg Foundation for Mental Health, University of Texas, Austin, Texas

Afternoon Session

There will be no formal session. Those interested may visit O.T. departments in Houston and Galveston.

RESERVATION INFORMATION

The Shamrock, in cooperation with your local committee, has provided special room rates for the conference of the American Occupational Therapy Association, November 13-20, 1953.

Rooms will be $12.00 for one or two persons per room, $15.00 with three per room, and $18.00 for four per room (excluding suites). Reservation cards will be mailed with the August Newsletter.

Don't forget to enter the art exhibit at the conference (See AJOT, March-April, 1953, page 101). Deadline November 5, 1953. Send pictures to Dorothy S. Hines, 4616 Evergreen Street, Bellaire, Texas.

Convention Personalities

WESLEY WIKSELL, Ph.D.

The banquet speaker at our 1953 conference will be Dr. Wesley Wiksell, consultant on communication in industry at Louisiana State University. One of Dr. Wiksell's favorite titles for the type of presentation he is scheduled to give us on this occasion is the provocative "Have You Tried Listening?" This topic is described as "a new kind of lecture with role playing and visual aids" and from all reports it will be dynamic, educational, stimulating and humorous.

Dr. Wiksell originated the first communications course in the United States and has lectured on human relations and communications for ten years. He has held teaching positions at the University of Missouri and Stephens College where for twelve years he was head of the communications division, at Ethyl Corporation, The Pan-American Corporation and Esso Standard Oil Company, and is the author of numerous articles in professional journals on various aspects of communications.

Holding both his bachelors' and masters' degrees from the University of Iowa and his Ph.D. from Louisiana State University, Dr. Wiksell has also done post-doctorate work at the Universities of Wisconsin, Chicago, Columbia and London. He has traveled through Norway, Sweden, Denmark, Belgium, Germany, France, England and Scotland.

Dr. Wiksell is vice-president of the National Society for the Study of Communications, and a former president of the Speech Association of Missouri; chairman, speech section of the Louisiana College conference; and president, Associated Civic Clubs of Columbia, Missouri. He is a member of the American Society of Training Directors, the American Association of University Professors, the Speech Association of America, the National Society for the Study of Communications, Kiwanis and others.

Listed in *Leaders in Education, Directory of American Scholars,* and *Who's Who in American Education,* Dr. Wiksell is a special consultant to professional groups on communication problems, on speeches, conference leadership, parliamentary law and engineering by consent.

The members of your local conference-planning group who have heard Dr. Wiksell speak assure

you that he will have a worthwhile and pertinent message for our group.

MRS. FRANCES D. ALTERMAN

Young people finishing high school are frequently asked what their plans are for the future. More times than not, young people do not know. Frances Dunlap Alterman thought she would become a nurse and still get a B.S. degree by going to Antioch College, where students were permitted to work part time and go to school part time. What became obvious in the beginning was that educational arrangements along these lines could not be scheduled due to college administrational problems. Furthermore her music life, primarily piano, had been shelved. At the end of the year, therefore, she transferred to the Eastman School of Music where she majored in voice and piano and obtained her degree in music from the University of Rochester. Following this, she went to New York to continue her study and ostensibly to seek a music career.

About the middle of the 30's, Frances met a physical therapist who was working at New York Hospital and who was employed by a leading physiatrist and director of an approved school, Dr. K. G. Hansson. She had been exposed to physical therapy at a crippled children's hospital while on a work period at Antioch College. It had seemed an interesting and worthwhile activity, suggesting perhaps the ideas behind an original wish to go into hospital work. She applied and was rather jokingly told that music and physical therapy didn't have much in common. However Dr. Hansson didn't offer serious objections and, after earning her professional certificate, Frances went to work at the Hospital for Special Surgery, half days, maintaining her musical career the remainder of each day.

At the outbreak of the war she entered the 45th General Hospital at Camp Lee, Virginia, and went overseas in the spring of 1943, serving as chief physical therapist in her unit throughout the war at hospitals both in Africa and Italy. She returned home before Christmas of 1945.

Following the war, Frances married and, as physical therapy then became an avocation, she used the G.I. bill to take some coaching under several well-known musicians at Juilliard School of Music. Then along came John, a fine big boy, born in 1947.

As music could not be kept out of her life, neither could physical therapy, and in September 1947, she became chief physical therapist at the Alexandria, Louisiana, Veterans Administration Hosptial. Subsequently, when the Houston Navy Hospital was taken over by the Veterans Administration, Frances was asked to come over and set up the department.

Having a liking for teaching and personnel management, she requested permission to use the G.I. bill again before it expired, and after fifteen months in Houston, she headed for Columbia and a master's degree in education. This was accomplished in combination with part-time physical therapy work for the Rockland County Public Health Association.

At the termination of the school year, her intention was to return to Houston, but at that time Central Office requested a change of duty to Oteen Veterans Administration Hospital near Asheville, North Carolina. In December of 1951, she took up her work at Oteen. A program was going on which was exciting to be a part of: the rehabilitation of the tuberculous patient. The concepts of treatment are changing and the role of physical therapy has become increasingly important in the plan.

Presently, Frances is quite busy preparing for physical therapy students in clinical practice from the Medical College of Virginia. She is looking forward to a reunion with her many friends in Texas and we are looking forward to her participation in the fall conference.

DR. MARGARET WATKINS

Dr. Margaret Watkins, who will speak at the national occupational therapy convention on "Trends in Treatment of Cerebral Palsy," is a person the Texas Occupational Therapy Association would like to know. She was born in Dallas and says she comes from six generations of Texans. A soft Texas drawl and a picturesque manner of speaking bear out this statement. Dr. Watkins received her bachelor's degree at the University of Texas and her degree of doctor of medicine from the Baylor College of Medicine in 1938. Following four years of residency in orthopedics, she began practice in Dallas.

Dr. Watkins has become outstanding in her field. For ten years she has been clinical instruc-

(*Continued on page* 189)

FEATURED O.T. DEPARTMENTS

OCCUPATIONAL THERAPY DEPARTMENT CITY-COUNTY HOSPITALS

Dallas, Texas

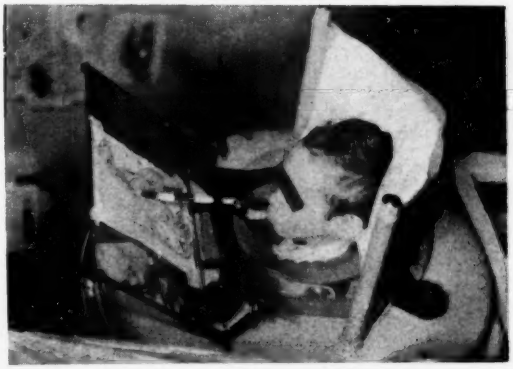
Cornelia Watson, O.T.R.

To invite you to take a trip through the present occupational therapy department in the city-county hospital system in Dallas would be not only time-consuming but also exhausting because the department is scattered rather widely. The tuberculosis unit is a mile or more from the general hospital, and the convalescent home is on the outskirts of the county, many miles from either of the above.

The electric sewing machine is used to repair patients' clothing as well as to make new articles. This woman needed praise and encouragement in fulfilling a stimulating, short time project. This type of home hobby has given her an added method of gaining family appreciation.

Therefore let me take you on one of the now popular "armchair tours" through our department. In 1946, the hospital administrator felt that occupational therapy was a needed addition to the treatment program for the patients. However it was not until 1948 that Miss Katherine Little initiated and organized an occupational therapy program. Funds were not available for either the salary or the supplies so the women's auxiliary agreed to sponsor this pilot project for a three year period. A staff of 25 volunteers was trained to assist with the patient program on psychiatry and pediatrics in the general hospital, while Miss Little treated the patients at Woodlawn, the tuberculosis unit, and supervised the work at the convalescent home.

In October, 1949, a second therapist joined the staff to expand the group therapy technique used in psychiatry and to incorporate an individual treatment program for those patients. The following year a third opening in occupational therapy was created by the hospital, with all salary expenses assumed by the hospital and a monthly budget for operating expenses allotted by the women's auxiliary.



This patient has needed respiratory assistance since last year's epidemic of poliomyelitis. He is learning to read by coloring and drawing techniques, utilizing a mouthpiece to hold crayons and soft lead pencils. A metal frame fastened to the side of the mirror allows him to place the mouthpiece on the frame while talking or resting. Plastic cars, glued to small magnets, fasten to the mirror and can be readily moved around with the same mouthpiece.

The occupational therapy program at Woodlawn, our 100-bed tuberculosis unit, is predominantly one of working with patients who are on bed rest. It is felt that the number of patients leaving the hospital against medical advice has dropped at least 10% since occupational therapy was instituted. Demand for bed space does not permit the patients to be hospitalized beyond the three or four activity classification. Crafts and a pre-vocational training program are utilized, with regularly scheduled movies and a monthly newspaper, called the "Woodlawn Wheeze", as additional recreational activities. A group of volunteers assists with weekly shopping, fulfilling the patients' personal needs. The entire program of occupational therapy is used to induce physiological rest by means of a work tolerance program. The length of time allowed for activity and the physical endurance required by the craft are discussed and prescribed for each patient by the doctor at the weekly conferences. There is a close teamwork approach with assistance of vocational counselors for further training of the patient following discharge. Plans are being formulated to include occupational therapy in the follow-up clinics in an attempt to lower the percentage of readmissions and to help the patient adjust to an altered regime of living. The large office and storage area is available to those who are allowed ambulatory privileges each day.

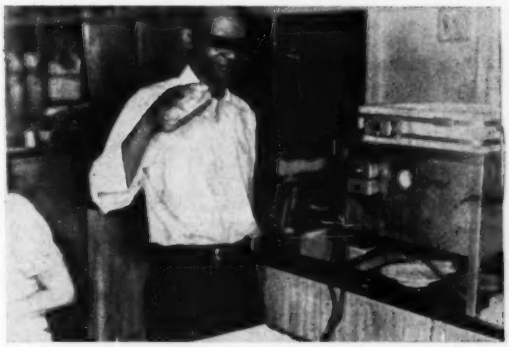
The program at the convalescent home at this time is one of furnishing funds for supplies for the patients' craft endeavors and of assisting the regular staff personnel with suggestions for new activities as needed. The patient load at the home consists largely of the aged. When the home is moved in 1954, there are plans for group therapy and individual treatment of the younger patient when indicated.

Parkland is the 416-bed general hospital, caring primarily for the indigent in the city and the county. We are in the process of growing pains which accompany the planning and building of a new memorial hospital, at which time the capacity will be greatly increased and the facilities improved. The hospital is definitely classified as a teaching center. There is a nursing school and an X-ray school in the hospital organization, and affiliates from the vocational nursing school train at Parkland. Occupational therapy affiliates receive their training in psychiatry, pediatrics and tuberculosis in the hospital system. The Southwestern Medical School of the University of Texas utilizes the hospital system as its primary teaching center for the medical students.

At Parkland Hospital the program is divided. One therapist has a full-time clinic with the psychiatric patients. Here occupational therapy is used as a diagnostic aid and as a treatment adjunct. The medical referral is complete with an outline of the basic objectives for the patient, the attitude to assume toward the patient and the recommended type of activity to be used by the patient. The present 32-bed ward is primarily a diagnostic and active treatment area so the patient's hospitalization averages only one month. Discharge or transfer to the state hospital system results at the end of this period, depending on the prognosis. The students nurses have a lecture and observation period in occupational therapy and the other personnel solidify the over-all treatment of the patient by weekly conferences. The occupational therapy clinic area for these patients is far away from the actual ward space affording the patient an opportunity to have freedom from the locked area each day. There is an adjoining outdoor area for such games as volleyball and croquet. The hospital is within easy hiking distance of a city park where picnics are often planned.

Independence is stressed in occupational therapy. All of the facilities for maintaining the patient's personal clothing are available and many times other patients help those unable to care for their own things. The patients help with the preparation of simple refreshments and, with medical approval, ward work is assigned to the patients when indicated. The crafts used for each patient are dependent on the medical referral. Regularly scheduled sixteen mm movies are shown for all the patients on the ward.

The third therapist on the staff works with the patients from the other services as indicated by medical referral. A regular program on pediatrics consists of recreation, music and crafts for all of the children once each day. There is no specific referral for these children unless the child requires special planning for a more extensive treatment plan. The student nurses on pediatrics have an orientation and work experience in occupational therapy to strength their appreciation and use of play for the hospitalized child. The local Aquarium Society has helped equip adequate bowls with fish for use as a sedative and an adjustment for the apprehensive child.



This patient is wedging clay, prior to modeling a free-form ashtray. He has already learned other ceramic techniques, all of which have been used to build his self esteem and alleviate his anxiety. During the actual wedging process, he has had a means of expressing his hostile feelings in an accepted manner.

Following the isolation period, occupational therapy is instigated for the polio patient still needing the respirator or rocking bed to overcome respiratory distress. The occupational therapy program is one of planning appropriate activities, making necessary equipment to expedite these activities and planning recreational programs of movies and games. Reading racks, mouth pieces for writing and coloring and magnetic games have been adjusted to meet the needs of individual patients. Hospital maintenance has assisted with the metal work required for these adaptations. As on the other wards, the goal of treatment has been that of independence for patient within his medical limitations.

Other hospital patients are seen when indicated by the referring physician. At present the predominant patient load from this group has been the cardiac patient and the paraplegic requiring skin grafting. For these patients the concern in occupational therapy is one of giving activities to be done in the hospital but which can also be utilized following discharge.

The occupational therapy floor space in the new hospital is quite encouraging because, besides the 730 square feet allotted for the central clinic, office and storage room, there is sufficient space in the sunrooms of each floor to keep necessary supplies and equipment. Particular attention will be on the pediatrics ward with a play room and ward areas. This will increase the present 23-bed space to the planned 48-bed capacity and isolation unit of 28 more beds for children. The actual plans for the other areas are still nebulous but when the hospital is opened and the occupational therapy clinics operating, we are certain that they will be well-equipped and organized to benefit the various patients being treated in the hospital, as well as out-patients from orthopedics, tuberculosis, psychiatry and the other hospital departments.

MOODY STATE SCHOOL for CEREBRAL PALSIED CHILDREN

Galveston, Texas

Dorothy M. Sniffin, O.T.R.

The Moody State School for Cerebral Palsied Children is the development of a dream of its superintendent, Miss Robertine St. James, R.P.T. Here, after years of experience in treating the cerebral palsied, she has had the opportunity to put into action her ideas for a twenty-four hour school with all therapies well represented.

This resident school, supported by the state and operating under the Board for Texas State Hospitals and Special Schools, is devoted exclusively to treatable, trainable cerebral palsied children, five through twelve years of age. Its present capacity is forty-three beds.

A child, to be eligible, must have average or better intelligence, must be toilet trained, must be non-convulsive or free from convulsions for the previous year and parents must prove their interest and ability to cooperate in a home treatment program. This is accomplished by a referral, at the time application is made, to the out-patient cerebral palsy treatment center nearest the applicant's home (there are some 24 of these sponsored by the Texas Society for Crippled Children). The medical and technical staff of these centers evaluate the children and teach the parents a home treatment program. Three months later the child is reevaluated and if the child's response to treatment is satisfactory, a referral to the school is made. Final application papers are again reviewed by a five-member screening committee consisting of an orthopedist, pediatrician, psychologist, nurse and the superintendent. Once admitted to the school, the child has a probationary period of treatment with maximum stay of about one year. Children who had a particularly difficult adjustment period or those who will return to localities lacking opportunities for further training may have their time extended beyond the listed twelve months.

Primary objectives of the school are: (1) Intensive therapy and education; (2) Training of professional personnel; (3) Clinical research. In this article the first objective, the therapy program, is stressed. The professional staff works a forty-four hour, five and a half day week. Each eight hour day is divided into eleven half-hour units, with a spread of two hours at noon to cover dinner and the children's rest. Children are scheduled for two hours of special education daily, one hour of standing table, one half hour each of speech, occupational therapy, physical therapy and functional therapy. To fit all these therapies into a daily routine requires close timing. In order to schedule the children for maximum benefit, special education first tests them for their group level—educational, visual and with regard to motor handicap and experience. The master schedule is then built around these groups. Each department will have some problems which require special timing as in toileting, extra rest, or for longer periods in some of the occupational therapy classes.

Because of its group activities, occupational therapy comes next on the schedule planning. Group activity developed through personnel shortage has shown itself to be an excellent, if unorthodox, method of treatment. Another unorthodox treatment method, due to the short-term intensive program, has been the development of use-requirements taking precedence over long term muscle-nerve correction. Individual therapy is given to children who are too distractible or too slow to benefit from competitive work or as reinforcement in training a specific modality.

The modalities covered in occupational therapy are, briefly:

1. Balance and posture needs
   Trunk balance
   Head and neck control
   Correction of a strong T.N.R.—(tonic neck reflex)
2. Dominance testing — developing of dominance and laterality

3. Hand activities:
   Eye to hand coordination
   Reach, grasp and release and thumb opposition. Area placement
   Hand skill development
4. Self feeding
   Control of drooling
   Straw drinking to develop swallowing technique, and lip and tongue control
   Spoon feeding—from full assistance to independence
   Glass drinking—management of a regular glass
   Final feeding skills—use of knife and fork, spreading bread, neatness
5. Dressing
   Gross dressing
      Use of practice pieces at supporting table
      In and out of large, loose garments
   Fine dressing—fine details on garments
      Techniques of one-handed or two-handed bow tying
      Buttons, zippers, snaps
   Complete dressing—in and out of all garments, including braces
6. Pre-writing skills
   Finger painting
   Crayoning
   Writing between lines
   Typing—with and without shielded typewriter
7. Activities for successful daily living as applied to the young C.P. child
   Getting into and out of chair
   Picking up objects from floor
   Crossing room to desired spot
   Opening and closing door
   Managing panties or trousers at toilet
   Personal grooming—washing face, combing hair
8. Preliminary activities which are the basis for future vocation
   Use of jumbo sized P.B.X. board for reach, grasp, release
   Eye to hand coordination. Response to sight and sound. Preliminary vocational training
   Household activities
   Carpentry

Some children may need to be carried through the whole range of listed modalities. Others may be so skilled as to need only a polishing up of abilities. Children have been entered who have no body balance, who need protective support when lying down and complete restraint when sitting. These children cannot be expected to progress in hand skill and use while unstable in body. However they can progress to hand use very rapidly, as soon as a fitted tray-chair is made, and more rapidly when the child has braces which stabilize his body and over flow is cut down. Though a six-page initial evaluation chart is outlined, children start work immediately with the most nearly possible skill of the greatest need. Thus a child who has so much involvement that active skills like dressing cause too much over-flow and incoordination, when properly restrained the child may start self-feeding practice with adapted equipment.

Lack of head and neck control make first steps in occupational therapy especially difficult. The treatment program in this case will depend upon the condition—whether there is involvement of the neck rotators, a weak trunk, severe scoliosis or no experience in sitting due to lack of training. A strong tonic neck reflex, causing the head to turn to the side of the extended arm and hand, may be considered a head and neck problem and must be corrected before useful hand actions can be developed.

Reach, grasp and release are basic motions needed for useful activities throughout human life. Treatment for these needs is nearly uniform throughout the country. Two gadgets particularly useful with problems of reach, grasp and release are: (1) when the opposite hand interferes (as in crossed over-flow, or in mirror action) and (2) when the child has used the last three fingers of the hand so consistently that thumb opposition has not been developed. For the first, a washable, expanding cloth wristlet, with long tapes and slide buckles so that the offending arm can be tied out of the way, is used while the acting hand is learning its job. For the other, several sizes of small gloves which fold the last three fingers into the palm of the hand and have openings to expose the index finger and thumb are used. Though true opposition is not immediately developed, especially in cases of subluxated thumbs, use of the thumb and fore-finger are greatly improved.

In dressing skills we have found it advisable to move away from practice button and bow boards and practice shirts and sweaters as rapidly as possible. Children start on their own clothing and in the natural environment almost as soon as their initial evaluation is complete. Undressing is practiced in the dormitory in the last half hour of the day—removing all clothing and braces, and getting into night clothes. Dressing is practiced the first hour of the day in the dormitory—getting out of night clothes, into braces and day clothes. Children in these classes are allowed to have breakfast and supper while still in their night clothes. A detailed listing of all steps of dressing and undressing is part of the regular graph and each step is dated when accomplished. It is in these classes that group competition has shown its value as a wonderful spur to constant improvement.

In feeding skills, the children are moved forward as soon as possible. Here there is not time to wait, nor should the children spend years of frustration in striving for a perfected physical pattern. The child may eat with arm abducted and flexed, bringing the head to the hand if need be. Or if he lacks consistency of grasp and cannot control wrist motion, he may start feeding practice with a fitted spoon splint and plate guard against which he can push the food to fill the bowl of the spoon. The child advances to eating his noon day

meal in the dining room as soon as he can get a loaded spoon off the plate and into his mouth.

The opposition glove is used in pre-writing when typing is indicated and the child has difficulty in isolating one finger and tends to strike several keys at once. The wrist restrainer may be used to hold a hand down to the work table.

The jumbo P.B.X. board, first of its kind in this country, was made by members of the local telephone company. This piece of equipment was designed to give training in reach, grasp and release, eye-to-hand coordination and response to sight and sound to children chronologically and mentally above the pre-primer level usually offered for these activities. Practice at this real telephone may also be considered pre-vocational training.

Carpentry is offered here, in group activity, as an outlet for excess energy, a development toward a vocational study and as specific therapy for hand skill development.

Housekeeping activities are slated for the older girls. These include the ability to get food out of the ice-box, transfer it to the table, open a can of fruit juice or soup and pour its contents into a suitable container, set a table, prepare a simple breakfast and lunch and wash the dishes. This class is designed to give a certain amount of independence to both mother and child.

The aims in the occupational therapy department are:

1. Maximum achievement per child.
2. Total or partial independence.
3. Development of pre-vocational skills.

Progress in treatment cannot be honestly tabulated without complete records. The initial report gives a total picture of the child's physical and emotional status. A treatment program may be started before all tests are complete. Running accounts are kept daily and are the basis for quarterly reports to parents. Where feasible, graphs are kept weekly. Each child is seen routinely once every two months at a whole-day clinic held at the school. Medical advisors sit in, hear the reports from all departments, see examples of the children's progress and give recommendations for changes or advances in the treatment programs. Children are also seen at the clinic when special problems arise. To give maximum benefit to each child it is essential to know the work of all other departments and to correlate activities. Weekly staff meetings offer the opportunity of an inter-change of ideas for the best possible management of the individual child.

Parents visit the school one Sunday a month. Therapists make a point of coming in to talk to them at this time. At the time of discharge, all parents are expected to come for one to three days to see their child through his whole treatment regime and discuss recommendations for future treatment. A completely outlined treatment schedule is included in the discharge report.

The school is open to the public at all times though the majority of visitors are from the professional fields. Each department head is available for lectures and demonstrations in his own field. Students are welcome and have been trained in two-week, one-month and two-month courses.

The Moody State School for Cerebral Palsied Children is a new school, just beginning its third year. It has had many wonderful gifts from town and state which have materially expanded the quality of treatment which can be offered. It is a young school which hopes to grow in value and efficiency as its professional staff hopes to grow. We are proud of our little school and hope that you will come for an extended visit when you attend the American Occupational Therapy Association's conference in Houston in November.

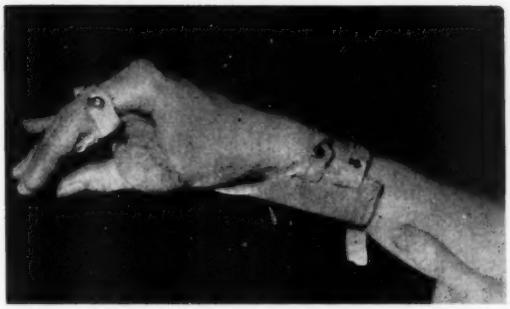
ARKANSAS CHILDREN'S HOME

Little Rock, Arkansas

Mrs. John Sorenson, O.T.R.

The Arkansas Children's Home and Hospital is due largely to the vision and inspired leadership of Miss Ruth Beall, its superintendent for the past 18 years. Taking over her job at a time when the hospital was buried under a seemingly insurmountable debt, she has put it on its feet financially and guided it into a position of leadership among Arkansas hospitals and children's hospitals in general. She has faith that what should be done will be done and then proceeds to achieve her vision. Her optimism and drive were the forces responsible for the creation of the new occupational therapy department at Children's Hospital.

In the summer of 1950, the hospital had no provision in its budget for an occupational therapist's salary, much less for equipment and supplies to set up an occupational therapy department. All it had was Miss Beall's desire for such a department and her faith that any obstacles could be overcome. When a therapist, a scarcity in the Arkansas job market, approached her for a job, Miss Beall hired



Opponens splint with wrist cock-up

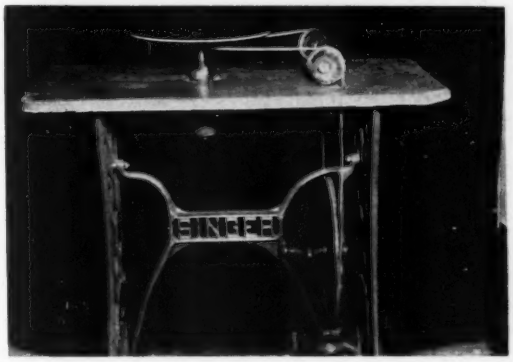
the occupational therapist first and set out to make financial arrangements afterward.

The generosity of an influential businessman helped solve the first problem. After a call for help from Miss Beall, he paid the occupational therapist's monthly salary until the hospital board approved the new expenditure.

From the first the superintendent professed no expert knowledge of the specialized field and gave the new therapist a free rein in organizing the department. Accepting the responsibility and initiative seemingly expected of her, the therapist's first working day was spent perusing the yellow pages of the telephone directory and making lists of manufacturers and jobbers who might have scrap materials to donate. These businessmen were contacted and willingly supplied scrap copper and aluminum, plywood, burlap and upholstery materials.

A big need, of course, was equipment. After learning of the need, several agencies offered assistance. The Pulaski county chapter of the National Polio Foundation provided a floor loom, Structo table loom, Peacock table loom, warping board, warp tensioner, spool rack and bicycle jigsaw. The Junior Red Cross purchased a small kiln, and various church and civic organizations bought toys, color books, shelving and bins, tools and other supplies and equipment. The therapist picked up three old sewing machines; left one as it was, adapted the second into a treadle sander and the third into a potter's wheel. An upright braid weave frame, various rug frames, an adjustable table, sling suspension, an adjustable over-the-bed table and a graded knee flexion and extension sling to be used by little children were made by the occupational therapist, laundryman and general handyman. Different types of sanding blocks, Montessori boards, a self-care brace and a combination wrist cock-up and opposition splint were also built at the hospital.

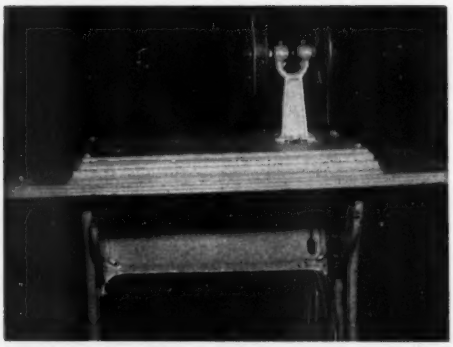
A major problem was space for the department. Although two second floor rooms were set aside for the use of the occupational therapist, the space was inadequate, and in case of a polio epidemic might have to be reconverted to wards. On impulse the occupational therapist took this problem to the Masons of Arkansas in late summer, 1950. Fate seemed to be working in the hospital's favor for the Masons were looking for a project they felt would benefit needy children of the state. They agreed to donate $25,000 for building a separate occupational therapy department if such plans could be drawn up and presented at their annual state-wide meeting in November, 1950. The plans were completed but before final approval, building expenses had increased until such a project would cost $36,000. However this added expenditure was also approved and the building was completed in midsummer, 1951.



Hospital made treadle sander

The architect consulted with the therapist about plans and asked her to submit a rough sketch estimating space required, needed storage, work areas and office and waiting room arrangements. Among results are adequate space around all equipment and an eye-level glass partitioning in the office which allows the therapist shop supervision when she must do paper work. In the shop there are two large storage closets and one end is lined with sliding door cabinets. Toilet facilities were built off the shop and waiting room areas, a sink is in the ceramic section, and special tables were constructed for weaving and soldering.

As the building neared completion, the problem of office, shop and waiting room furniture arose. Again the Masons came to the rescue and furnished both office and waiting room. The Little Rock Council of Jewish Women, a group which had shown continued interest in the hospital's new endeavor through donations of craft material and volunteer aid, was told of the special needs in shop furniture. They decided to pay for the construction of four work tables specially built to allow for wheel chair patients. They also ordered a children's activity table, chairs of varying sizes and two adjustable floor lamps. Thus final arrange-



Hospital made treadle sander

ments for furniture were made before the building was ready for occupancy.

Of course patients were receiving treatment while the building was being constructed. However with occupancy it was possible to expand the program. At present the occupational therapist treats all kinetic patients, with a maid to transport patients and do general cleaning. However a group of volunteers has been trained to handle the diversional and metric patient program under her supervision. The hospital capacity is 75 beds, and the O.T. department so far has handled an average of 10 to 15 kinetic patients daily and about 30 diversional and metric patients. Since opening an out-patient service, it has treated from four to six patients a month on a daily, tri-weekly or monthly basis. In addition to its in-patient and out-patient program for children, the department now services adult insurance cases. One occupational therapy student was trained this past summer and others probably will be accepted. As more neurologists and orthopedic physicians are made aware of occupational therapy in the treatment of their patients, the out-patient service may be extended to include a wider variety of kinetic problems.

The Arkansas Children's Home and Hospital donates its services to needy orthopedic and general medical cases. Often there may be a question of where the next dollar is coming from. With an A-1 hospital rating and the reputation among lay people for giving excellent care to the needy, a way is usually found to set up such services as surgery performed by the specialists of Little Rock who donate their time and skill, its own X-ray department and laboratory, physical therapy and now occupational therapy. Because the hospital program has the approval of accrediting agencies, internes are trained in pediatrics and residents in orthopedics. Now O.T. has added its own training program.

With occupational therapy, as with the other special services, the hospital under the leadership of its superintendent has always dared to take the initial plunge and thus has continually broadened its field of service. As services are added, more Arkansans become acquainted with the program and offer the support which makes further expansion possible.

MOTOR SKILLS

(*Continued from page* 163)

19. "These Are Our Children." (A Schenectady Cerebral Palsy Picture.) 16 mm., sound, color, 17 minutes. On loan from United Cerebral Palsy Associations, 50 West 57th Street, New York 19, New York.
20. Whitehouse, Frederick A., "Should a C. P. Go to College?", *Cerebral Palsy Review*, September, 1950.*
21. Whitehouse, Frederick A., "Vocational Guidance for the Cerebral Palsied," *Proceedings Cerebral Palsy Institute*, November, 1950, pp. 127-128.*
22. Whitehouse, Frederick A., "Vocational Training in a Rehabilitation Center," *Journal of Rehabilitation*, January-February, 1951.*
23. Whitehouse, Frederick A., "When Does Vocational Preparation Start?", *Cerebral Palsy Review*, January, 1951.*
24. Whitehouse, Frederick A., "Teamwork—A Democracy of Professions," *Exceptional Children*, Vol. 18, No. 2, November, 1951, pp. 45-52.*
25. Whitehouse, Frederick A., "Teamwork, an Approach to a Higher Professional Level," *Exceptional Children*, Vol. 18, No. 3, December, 1951, pp. 75-82.*
26. United Cerebral Palsy Associations, Inc., 50 West 57th Street, New York 19, New York. Adult Vocational Committee. Annual Report. (Pamphlet No. 1) 1952.

* Reprints available from Institute for the Crippled and Disabled, 400 First Avenue, New York 10, New York.

DRAMA

(*Continued from page* 165)

and tigers in the jungle without mentioning copulation.

She was asked "why didn't she deal with the material at hand?" She replied she usually takes the roundabout way and trusts the listener to catch on.

After the patient left the stage she began a long dissertation about animals and farms. It was soon noted that she was not using symbolic language but giving snatches of her own experiences on her uncle's farm when she had been quite young. Her talk dealt with her observations of sexual behavior among the farm animals and the recall of an incident in which she was ejected from the company of the adult folks who sat in the kitchen and told "dirty jokes."

This information transmitted to her doctor who was seeing her in individual therapy helped to bring out certain problems about which she had a great deal of anxiety. The resolution of this anxiety helped in her eventually leaving the hospital.

Another schizophrenic patient with depressive features was willing to try to take roles on the stage

but needed to be urged and led onto the stage. Once there she was able to continue without additional help. She stayed with the role pretty well but would often lapse into silence from which she could not recover. These lapses into silence were treated as a matter of course and she was told she was doing the best that she could and was acceptable. This patient later indicated in another group that she preferred the drama group and said that it helped her a great deal. How it did so is actually not known but the relationship she was able to form with the leader indicated a readiness for individual help.

CONCLUSION

The degree to which dramatic activities can be carried out ranges from the soliloquy of a patient on an empty stage to the use of elaborate props and the whole literature of the drama. As a kind of giant projective technique, it tells much about those things which are threatening to the patient. For example, even in play they cannot act out their aggressive or hostile roles. Used as a protected area where the patient can test out the expressions of his personality, it provides a sense of support and accomplishment. The opportunities provided for socializing and bringing about a psychological awareness is limited only by the ingenuity of the director of the group. With adolescent patients it is an excellent approach. As a medium for the preparation of patients for individual psychotherapy it ranks with any of the other ancillary aids available in a psychiatric hospital.

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3. Parrish, M. H. and Mitchell, J.: Psychodrama in a State Hospital; *MentalHygiene* 36: 33-43; 1952.

ACKNOWLEDGEMENTS

To Dr. Isadore Tuerk, acting superintendent, for his generous cooperation, sympathetic interest and continuous help in making facilities available for this project; to Dr. Arnold H. Eichert, clinical director, for making patients available and his critical comments and the Altrua Guild whose constant support by supplying funds for equipment has made the most modern means of recording available.

DR. MARGARET WATKINS

(*Continued from page* 181)

tor in orthopedic surgery at Southwestern Medical School, and during that time has won membership in the American Academy of Cerebral Palsy and the American Academy of Orthopedic Surgeons. She is a cerebral palsy consultant for the Moody State School for Cerebral Palsy at Galveston. At the national physical therapy convention in June of this year, Dr. Watkins gave the medical background for the symposium on the care of the pre-school cerebral palsied child. She has contributed to the Texas Medical Journal and the Journal of American Medical Womens Association.

Dr. Watkins is well known in Texas, not only as a physician, but for her interest and active participation in community affairs. In recognition of this, she received the Zonta service award in 1948. Dr. Watkins helped start the Dallas Cerebral Palsy Treatment Center and has been generous in giving her time for medical supervision and the preparation of a manual to help parents understand the problems of cerebral palsy. She is now chairman of the medical staff of this treatment center. Dr. Watkins was also instrumental in starting the Childrens Development Center, a training center created for retarded, hyperactive and emotionally disturbed children not eligible for public school. In the Episcopal church she has served in the department of Christian social relations working with displaced persons, alcoholics and in marital counseling situations.

Despite her busy schedule, Dr. Watkins finds time to pursue a number of fascinating hobbies. An enthusiastic fisherman, she usually manages several fishing trips during the year and even ties her own flies. She is also interested in photography and makes color movies showing the progress of many of her patients. Several years ago Dr. Watkins bought an old Mt. Vernon-style home and, together with a friend, drew up the plans for remodeling it, contracted the job and did much of the work herself. She now has a lovely office and treatment rooms in the downstairs portion and rents out offices upstairs to other doctors. These are a few of the reasons why her friends regard her as such a talented person.

Through her contacts with the American Academy for Cerebral Palsy and as a result of her own professional experience, Dr. Watkins is a person well qualified to speak on recent trends in the treatment of cerebral palsy. We know you will enjoy her contribution to the conference program.

A unique art exhibition entitled "The Story of Medicine in Art" will be shown at the Milwaukee Art Institute from September 11 to October 25, 1953.

The exhibition will include paintings, drawings, graphics, sculpture, manuscripts, medals and stamps dealing with medicine. Museums throughout the land as well as private collectors and artists are cooperating to make this an outstanding show by lending items of real importance in the field.

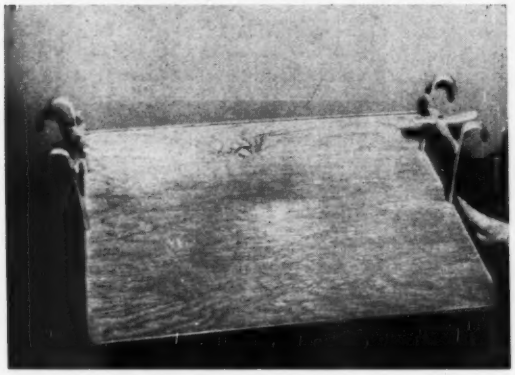
The Interpretational Gallery, correlated to the major show, will present art as a therapeutic medium in occupational therapy departments. Milwaukee-Downer College will execute and install the exhibit in this gallery.

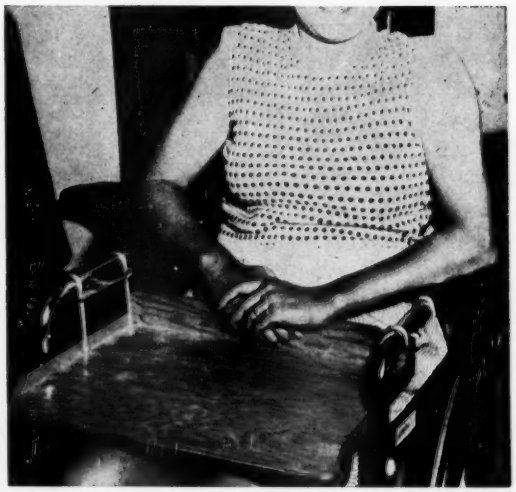
ADAPTED EQUIPMENT

SPECIAL EQUIPMENT ADAPTABLE FOR KITCHEN USE*

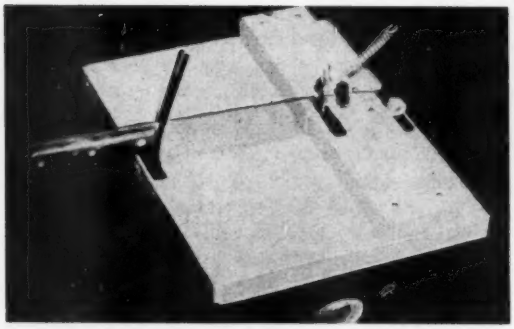
Viola W. Svensson, O.T.R.
Miriam C. Brennan, O.T.R.

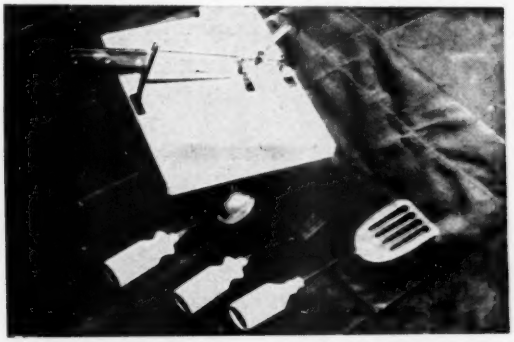
All this equipment was made primarily for patient's participation in her husband's business of a sandwich shop so that she could contribute towards their income as she did prior to disability.





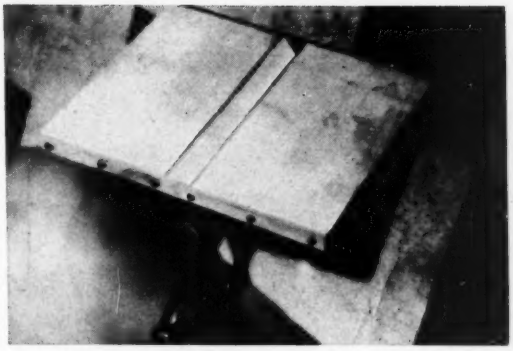
Lapboard: Clasps onto the wheelchair as can be noted—which makes it secure for carrying pots, pans, dishes, etc. It can be easily detached by the individual in the wheelchair as well as easily put on by someone else if necessary.





Cutting board with knife and utensils: Figure on the left shows knife down with spring attachment on the stretch. Figure on the right shows knife lifted and controlled by wing nut as to height of knife lifting. This wing nut can be regulated to any height desired depending on thickness of what is being cut. The knife is a regular French cook knife purchasable in any hardware or department store. Its tip is on a pivot mechanism which can be easily unscrewed for cleaning and sharpening. The utensils are specially adapted to fit the hand of the patient pictured using it. They are hollow for lightness.

*The third of a series of illustrations of apparatus aids toward independent activities as designed and constructed in the occupational therapy department of the New York State Rehabilitation Hospital, West Haverstraw, N. Y.

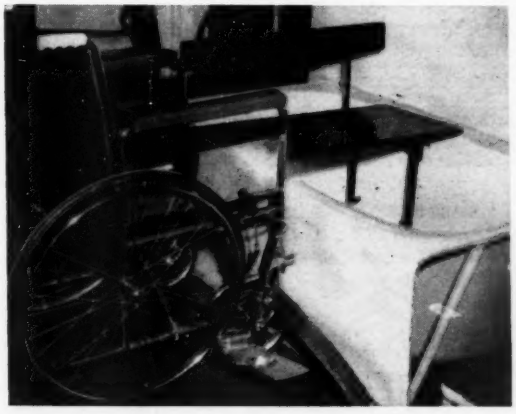


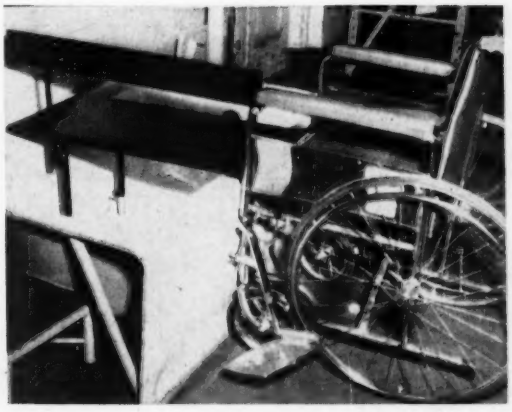
Closeup of the board underneath showing the inverted "V" to allow bread crumbs to drop through and not clog the knife slot.

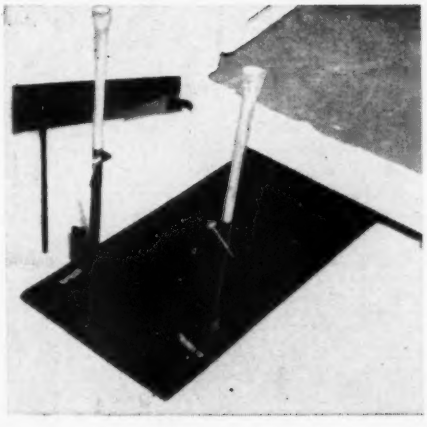
Pictures method of cutting bread which is simply done as depicted by the patient for whom these utensils were made.

APPARATUS AID TOWARD AN INDEPENDENT ACTIVITY

Viola W. Svennsson, O.T.R.
Miriam C. Brennan, O.T.R.







Bathtub seat: Excellent apparatus for severely handicapped patient for use at home. With its adjustable legs for height, it can be used in a variety of sizes of bathtubs. This was made for the physical rehabilitation department in promoting independent activity in this area.

AN ADJUSTABLE-SURFACE WORK TABLE

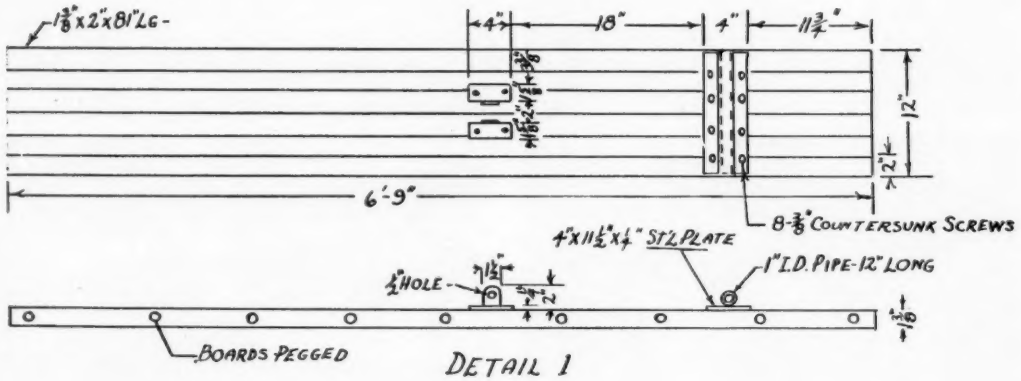
Shirley Esenther, O.T.R.

Curative Workship, Louisville, Ky.

The adjustable-surface work table provides a facility for obtaining a good range of gross functional and graded activity for disabilities of the upper extremities. Checking and correcting the position of the patient are simple procedures once the initial limitations are observed. Upgrading through the range of resistance and motion is initiated with a minimum standard of time.

An adult or child can work at the table from standing, sitting and wheelchair positions. The adjustable surface is quickly and easily placed by one person for degree of slant and for left or right side. It has been used primarily for woodworking, but it can be modified as an easel, as a mount for knotting frames and weaving frames and looms, or numerous other activities requiring a stable support of this kind.

The study and construction were supervised by an engineer of the International Harvester Company in its Louisville plant for the Curative Workshop of Louisville, Kentucky.



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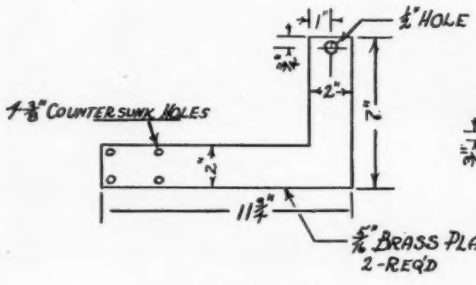

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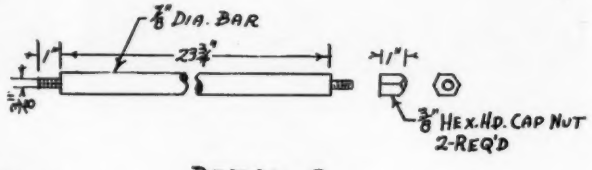

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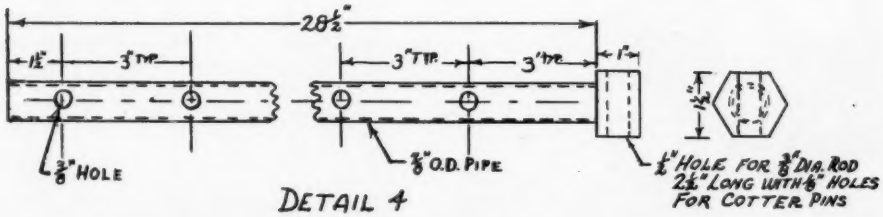

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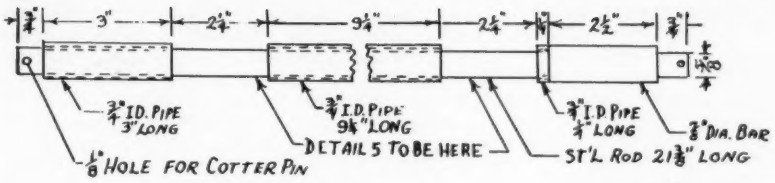

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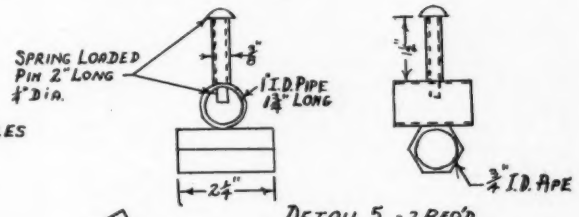
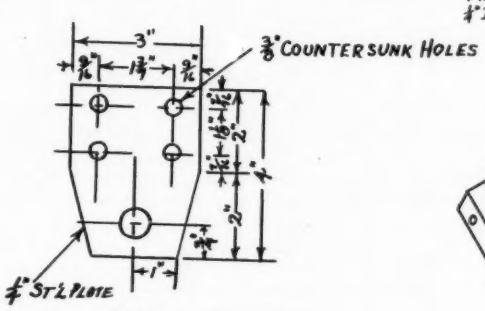


DETAIL 5 - 2 REQ'D



DETAIL 7 - 2 REQ'D

SPECIFICATIONS

No.	Req'd		
14	2	1¾" x 1¾" x 51"	long
13	2	1¾" x 1¾" x 20⅜"	long
12	1	1¾" x 1¾" x 60¼"	long
11	2	11 15/16" x 1¾" x 51"	long
10	2	1¾" x 1¾" x 51"	long
9	2	1¾" x 1¾" x 23⅞"	long
8	4	3½" x 3½" x 34 1/6"	long

DELEGATES DIVISION

FLORIDA

Delegate-Reporter, Pearl J. Tennyson, O.T.R.

On May 30, 1952, a group of interested occupational therapists, representing various sections of Florida, met at the Orange Blossom Hotel, Sarasota, and organized the Florida Occupational Therapy Association. Nine therapists, all O.T.R.'s, were present for this organizational meeting. Mrs. Phillip Dressler (Elisabeth Anthony), Fort Lauderdale, acting as chairman pro tem, called the meeting to order at 11:00 A.M., following an informal period of getting acquainted. After the election of officers and several impromptu speeches by members, the meeting adjourned for lunch.

Mrs. Sue Linsin, having been elected president, presided over the afternoon session which was devoted to informal discussion on organizational matters, the appointment of committees and the reading and discussing of a previously prepared draft of the constitution. Our constitution was ratified one month later, June 30, 1952, with 13 active members and 3 associates. Florida was accepted for membership in the House of Delegates at the annual conference of the American Occupational Therapy Association, in Milwaukee, 1952.

Since the initial meeting the organization has grown to 18 active and 4 associate members. We received two by transfer, one from Ohio and one from Texas, and lost one to Michigan.

The present plans are to schedule two meetings yearly, probably in May and November, but area meetings are being encouraged. Miami has held one such meeting under the leadership of Mrs. Christine Kimball, our vice-president.

The second meeting of 1952 was held October 12-13, at Miami, with 15 members present. The opening session was held in the afternoon at the Roosevelt School for Exceptional Children. In addition to the business, the delegate read her report of the House of Delegates and of the A.O.T.A. conference at Milwaukee. Following a wonderful chicken dinner and social hour, Mrs. Christine Kimball, director of O.T. at the Roosevelt School, introduced Miss Stein, speech therapist at the school, who gave an interesting talk and demonstration on speech methods for the cerebral palsied. Following this Miss Helen Smithson demonstrated some techniques she has found most useful in treating hemiplegic patients.

The second day of the meeting was devoted to visiting occupational therapy departments in the Miami hospitals. Included were the Pratt VA Hospital at Coral Gables, with Mrs. Francis Gerlack and Mrs. James Mason as hostesses, and the new Hospital for United Cerebral Palsy Association with Miss Helen Smithson as hostess.

The first meeting of 1953 was the annual one held at St. Petersburg during the month of May. Since our association is not yet a year old, all our efforts have been concentrated on organization and recruitment of membership. All hospitals in the state have been contacted in an effort to locate and interest members of our profession, or in the event of no existing department to interest the hospital officials in occupational therapy. The latter has resulted in several requests from hospital superintendents for the names of available therapists.

Many of our members have participated in career day programs throughout the state with encouraging results. Plans will be discussed at our next meeting on ways and means of establishing an association scholarship fund.

Very few of our members are natives of Florida. Much credit for the organization of an association is due Miss Jane Northen, of Sarasota, (Jane, although one of our youngest, boasts of having lived in the state longer than any other member). She conducted a "one woman" campaign for several years but it was not until 1952 that Florida really had enough qualified occupational therapists to form an organization.

Although our association is new and the membership small, it is felt that much progress has been made during our first year. Due to the extreme length of Florida, and with members from Miami to Tallahassee, travel presents the greatest problem.

Our ambition is to develop a strong association for Florida and some day play hostess to a national occupational therapy conference so that each and every one of you will be privileged to enjoy our wonderful sunshine.

OFFICERS

President	Sue L. Linsin, O.T.R.
Vice-President	Christina C. Kimball, O.T.R.
Secretary-Treasurer	Jane D. Northen, O.T.R.
Delegate	Pearl J. Tennyson, O.T.R.
Alternate-Delegate	Helen Smithson, O.T.R.

KENTUCKY

Delegate-Reporter, Berla Thomas, O.T.R.

The Kentucky Occupational Therapy Association has a membership of 24 active members and 10 associate members. One of our faithful active members and former delegate, Miss Nell McCulloch, has transferred to the Western Pennsylvania state association. We have added a number of new, active members during the past year.

Nine very interesting meetings were held this year. The first was our annual joint meeting with the Indiana group, Kentucky being the host. A luncheon was served at the Pendennis Club, Louisville, Kentucky, with appropriate favors and corsages. Trips were taken to Mary Alice Hadley's Pottery Shop and Lou Tate's Little Loomhouse.

A meeting was held in November at Silvercrest Sanatorium in New Albany, Indiana. The program for the year was outlined and a summary of the conference at Milwaukee was given by the alternate delegate, Mrs. Patricia Moyer, and the president, Miss Carol Apple.

In December, a joint dinner meeting of physical therapists and occupational therapists was held at the Henry Watterson Hotel. This was a festive Christmas dinner, after which movies on the retraining of the polio hand were shown and discussed.

In January we had a most interesting time in Lexington at a luncheon at the Campbell House. Our guest speaker was Dr. A. Dudley Roberts of the Lexington V.A. Hospital. He spoke on projection techniques and supplemented his talk with finger paintings done by patients. Miss Apple read a letter from Miss Dorothy Bromwell, Director of O.T. at the Astley-Ainslee Hospital, Edinburgh, Scotland, thanking us for our letter concerning books and materials on O.T. which we have gathered at our meetings to send to Scotland.

Our February meeting was held in Louisville at the V.A. Hospital. Material was distributed on the national conference on rehabilitation centers that was held at Indianapolis. Films on polio and hemiplegia were shown and discussed by the group.

In March a meeting was held at the home of Berla Thomas in New Albany, Indiana, to which all volunteers and prospective associate members were invited. An informal round table discussion was led by Shirley Esenther on the role of the volunteer in O.T. An outline of pertinent questions had previously been sent to all members so there was a very constructive discussion.

An executive council meeting was held in April at the home of Elizabeth Richmond in Louisville. This was primarily a business and social meeting.

Our regular meeting in April was a panel moderated by Dr. E. E. Landis, chief of the psychiatric service, Norton Infirmary, Louisville, Kentucky. The topic discussed was the correlation of various rehabilitation departments in a hospital. Those on the panel included: Miss Connie Popio, group social worker; Miss Shirley Esenther, occupational therapist; Mr. Mel Carson, physical therapist; and Mrs. Nelle Peterson, head of the art department of the University of Louisville. To this meeting we invited physical therapists, social group workers, speech therapists and corrective therapists. This proved so interesting and enlightening that we have decided to continue these panels at intervals during the year.

Our annual founder's day luncheon was held in Lexington, on May 16th. The speaker was Dr. Israel Muss, chief of the physical medicine rehabilitation service of the Louisville V.A. Hospital.

Our recruitment committee has been busy this year. Material has been sent out to all high schools in the state; a table of books and pamphlets was in the lobby of the exhibitors building at the Kentucky Educational Association convention. Several members of the K.O.T.A. have given talks before interested groups. So we are still "Carrying on" for more OT's.

Hope to see you all at Houston in November!!

OFFICERS

President	Carol Apple, O.T.R.
Vice-President	Janet Wimpleberg, O.T.R.
Secretary	Elizabeth Richmond, O.T.R.
Treasurer	Toyne Harris, O.T.R.
Delegate	Mrs. Berla Thomas, O.T.R.
Alternate Delegate	Mrs. Pat Moyer, O.T.R.

NEW YORK

Delegate-Reporter, Marguerite Abbott, O.T.R.

The New York State Occupational Therapy Association has had four interesting and well attended meetings during the year 1952. The average attendance, including non-members, was sixty-four.

The topic for discussion at our first meeting was, "Know Your Community Resources in Vocational Rehabilitation." Our speakers were from N.Y. State Employment Service, Division of Vocational Rehabilitation, and the Federation of the Handicapped.

Our second meeting centered around a discussion of the aspects of medical care, occupational therapy and the social situation of the aged.

Another interesting meeting was on the subject, "Occupational Therapy and Rehabilitation in Foreign Countries," conducted on a panel discussion basis. Included was a report on the formation of the World Federation of Occupational Therapists.

At our fourth meeting highlights of the annual conference at Milwaukee were given and a film on the training of the deaf child, illustrating the work of the Lexington School for the Deaf, New York City.

We have participated in community affairs by our continued relationship with United Hospital Fund through the sponsoring of the occupational therapy volunteer training committee. One of the most important activities of this committee is the training course for volunteers which is offered in October and continues for nine weeks. The majority of instructors for this course are registered therapists.

A permanent traveling exhibit was constructed and completed in time to be sent to the American Psychiatric Association convention at Atlantic City in May. Upon request it was later sent to the Pennsylvania Psychiatric Nurses convention in Norristown. Mr. Percy Clark was the chairman of this committee and did an outstanding job in designing and building this exhibit.

The Bulletin of the New York State Association was published four times during the year bringing to the members important announcements, resumes of meetings, highlights of featured O.T. departments, new ideas and references in O.T. and allied fields and many other interesting features.

OFFICERS

President	Frieda Behlen, O.T.R.
Vice-President	Frances Shuff, O.T.R.
2nd Vice-President	Margaret MacGregor, O.T.R.
Recording Secretary	Kathryn Ballantyne, O.T.R.
Corresponding Secretary	Manuel Brown, O.T.R.
Treasurer	Agnes Ness, O.T.R.
Assistant Treasurer	Rhoda Ash, O.T.R.
Delegate	Marguerite Abbott, O.T.R.
Alternate Delegate	Helen Mathias, O.T.R.

NEBRASKA

Delegate-Reporter, Sophia R. Lindahl, O.T.R.

Plans were discussed in the last meeting of the Nebraska Occupational Therapy Association to secure a scholarship in occupational therapy under the auspices of the American Legion Auxiliary which will be similar to their scholarship for student nurses. One scholarship is available in occupational therapy at the present time under the auspices of the Junior League of Lincoln. The latter specifies the student return to the state and work in cerebral palsy centers.

At present there are twelve institutions in the state having registered occupational therapists. To date this is one less than the maximum number of hospitals that have requested registered therapists. Within the next fiscal year this number is to be increased if available therapists can be secured.

The Nebraska Occupational Therapy Association has been functioning as such for two years but had been in existence for several years previous as a non-affiliated organization. Though an infant group with a minimum of members, we are advancing slowly, but surely.

OFFICERS

President	Sophia R. Lindahl, O.T.R.
Vice-President	Ruby Benjamin, O.T.R.
Secretary	Thelma Bullard, O.T.R.
Treasurer	Sister Tillie Olson, O.T.R.
Publicity Chairman	Mrs. Mary Timlin, O.T.R.
Delegate	Sophia R. Lindahl, O.T.R.
Alternate Delegate	Sister Tillie Olson, O.T.R.

SOUTHERN CALIFORNIA

Delegate Reporter, Miriam Thompson, O.T.R.

"Quo Vadis, O.T.?" Whither goest occupational therapy? This was the theme of a recent successful meeting between the Southern California and the Northern California Occupational Therapy Associations. The meeting was held in Paso Robles, California, with approximately 60 occupational therapists attending the two day conference. Both associations participated by presenting very interesting and professionally worthwhile panels. This was only one of a series of extremely valuable monthly meetings conducted by the Southern California Occupational Therapy Association.

It was the expression of our membership that some of our monthly meetings be held in different hospitals in the area with the O.T. staff being responsible for the

presentation for the evening. We felt a more active participation by the occupational therapists emphasizing the part they play in their particular institution and new treatment developments would be beneficial to the group. In the past months meetings have been held at the Long Beach Veteran's Administration Hospital, the San Fernando Veteran's Administration Hospital and the Los Angeles County General Hospital. In addition to our meetings within various hospitals in the community we have continued to have our usually fine presentations by medical men within the area.

Our bazaar, which has now become traditional, was again a triumph. For some unknown reason, at least to us Californians, a slight precipitation usually arrives on the same day as our scheduled bazaar. The misty streets don't seem to dampen any of our group's spirits as evidenced by the fact that this year we were able to realize approximately $700.00 on the endeavor.

Recruitment has had a number one priority on our list of essentials. In cooperation with the WMSC of the Army, the Physical Therapy Association and the Dietetics Association of California we have undertaken an extensive recruitment campaign. A great deal of literature, many speeches, radio and TV appearances have assisted in what we feel has been a successful attempt at interesting new people in our profession.

Our first annual awards presentation was held at our meeting in May. Our purpose in the formation of this award banquet is to recognize and stimulate interest among our working therapists. Seven monetary awards will be given to seven therapists in each of the different fields. A panel of judges will decide which presentation in each of the fields has made the greatest contribution to that particular field.

Not all of our meetings have been business—we have had some delightful social meetings also. Our meetings are held on a monthly basis and our average attendance is between 55 and 65. Our total membership is 108 to date.

Highlights of the past year have been visits by Marjorie Fish, executive director of AOTA; Lucie Spence Murphy, editor of AJOT; and Martha Matthews, educational field secretary.

OFFICERS

President ..... Patricia Holser, O.T.R.
Vice-President ..... Ada Marie Bowers, O.T.R.
Corresponding Secretary ..... Diana Shelton, O.T.R.
Recording Secretary ..... Margaret Orchard, O.T.R.
Treasurer ..... Violet McCarty, O.T.R.
Delegate ..... Miriam Thompson, O.T.R.
Alternate Delegate ..... Florence Cromwell, O.T.R.

TENNESSEE

Delegate Reporter, Marian Zintek Beauchamp, O.T.R.

The Tennessee Occupational Therapy Association is continuing to experience growing pains not only in growth of membership but in variation of program and interests. We are very proud of this.

Since the distance between Tennessee's major cities is great, three weekend meetings yearly give the entire group a chance to get together. In March, Nashville is the meeting place. The April meeting rotates between states to form a tri-state meet, while the May meeting, our annual meeting for the election of officers, and regular monthly meetings are held in Memphis. Usually we average 17 members per meeting.

The major project for this year has been the organization and completion of a recruitment display. We hope that in the near future this exhibit will be ready for showing in the high schools, colleges and among civic groups throughout Tennessee. Recruitment has consumed a great portion of our time. Open houses for student groups as well as informal talks have added to our program. Even radio and television have been utilized whenever possible.

Since the majority of our members are located in Memphis, the total attendance of 21 at the March luncheon meeting in Nashville was wonderfully surprising. Dr. F. Tremaine Billings, Vanderbilt University Medical School, spoke on the heart and heart diseases.

In April, Tennessee played hostess to OT's from Arkansas and Missouri at the tri-state meeting. The Crippled Children's Hospital School proved a most satisfactory meeting place to hear a talk on cerebral palsy by Dr. Ingram and a panel discussion by the psychology staff of Kennedy V.A. Hospital. The Sunday morning coffee hour at the B'nai B'rith Home and Hospital followed by tours of Memphis OT departments concluded the weekend of meetings. This was an excellent opportunity to exchange ideas with OT's in neighboring states. The Tennesseans are now looking forward to the 1953 meeting to be held in St. Louis.

During August and September the OT's in Nashville conducted several classes for student nurses at Meharry Medical School to aid them in planning a program for geriatric, cardiac and blind home-bound patients. The two film strips, OT *Information Please* and *Occupational Therapy Unlimited*, were shown in an effort to better acquaint the group with occupational therapy as a treatment procedure.

Physical therapy and occupational therapy combined for the January meeting to hear a talk on the significance of the electro encephalogram, especially as related to emotional behavior problems in children. Dr. Jurko of Gailor Hospital and University of Tennessee Medical Units, Memphis, was a most interesting and informative speaker.

Our plans for the future consist of a renewed effort to further the profession by recruitment and education concerning occupational therapy. We are in the process of planning a workshop type of meeting or idea exchange in order to widen the scope of the members. We hope to continue our growing as a sign of progress.

OFFICERS

President ..... Ruth M. Zieke, O.T.R.
1st Vice-President ..... Joan Vermillion, O.T.R.
2nd Vice President ..... Marian Zintek Beauchamp, O.T.R.
Secretary ..... M. Gertrude Fike
Treasurer ..... Betty Hopton
Delegate ..... Marian Zintek Beauchamp, O.T.R.
Alternate Delegate ..... Joan Vermillion, O.T.R.

VIRGINIA

Delegate Reporter, Margaret Clarke, O.T.R.

The past year has been an interesting and profitable one for the Virginia Occupational Therapy Association. The following program meetings were presented.

April 19 the annual business meeting was held at the Veterans Administration Center, Kecoughtan, Virginia. In addition to the business meeting, Dr. L. H. King, chief of physical medicine and rehabilitation at the Veterans Administration Center, discussed physical medicine and rehabilitation at the Center. A tour of the various clinics followed.

June 7 the annual tri-state meeting was held at Spring Grove State Hospital, Catonsville, Maryland, with the Maryland Occupational Therapy Association as hostess.

A two day meeting was held at the Veterans Administration Hospital, Roanoke, Virginia, October 18 and 19. The delegate reported on the annual meeting of the house of delegates and the annual conference held in Milwaukee. At the dinner meeting Saturday night, Dr. Robert R.

Rudolph, chief of insulin shock therapy, spoke on the prefrontal lobotomy program at the hospital. The Sunday morning session was a floriculture seminar led by Heyward Horry, O.T.R.

The fifth annual joint meeting of the Virginia chapters of the American Physical Therapy Association and the Virginia Occupational Therapy Association was held January 10 at the Veterans Administration Hospital, Richmond.

March 7 the occupational therapy students at Richmond Professional Institute were responsible for the meeting on pediatrics. April 25 and 26 were the dates for the annual meeting held at Woodrow Wilson Rehabilitation Center, Fisherville, Virginia.

The Virginia Occupational Therapy Association will be co-hostesses with the District of Columbia Occupational Therapy Association for the 1954 annual conference of the American Occupational Therapy Association to be held in Washington. Planning is already underway. The members of the Virginia Occupational Therapy Association have been putting forth considerable effort to raise funds for special conference expenses and for the scholarship fund. Two projects have been quite successful. One, the sale of small occupational therapy insignia stickers, was initiated at the conference in Milwaukee. These are still available and may be ordered from the treasurer of the association. They sell 25 in a package for 50c. The second project has been the sale of flower and bird print note paper and post cards.

OFFICERS

President .....Margery C. Peple, O.T.R.
Vice-President .....Arthur Sundquist, O.T.R.
Recording Secretary .....Mary E. Blayney, O.T.R.
Corresponding Secretary .....Nina L. Hartline, O.T.R.
Treasurer .....Richard M. Young, O.T.R.
Delegate .....Ruth McDonald, O.T.R.
Alternate Delegate .....Beverly Bates, O.T.R.

WESTERN PENNSYLVANIA

Delegate Reporter: Marjorie E. Roth, O.T.R.

There were five regular and one special meeting of the Western Pennsylvania Occupational Therapy Association during the year of 1952, with an average of twelve members present. Invited speakers presented information on: The Transition of Art; The Effect of the New Drug Treatment in Tuberculosis, and the business of the association as well as that of the American Occupational Therapy Association was transacted.

A purse, made by a patient at the Cresson State Sanitorium, was raffled to raise funds for the association.

It is interesting to note that eight members of the association attended the annual conference of the American Occupational Therapy Association in Milwaukee, this number being about half of the membership at the time. Western Pennsylvania O.T. Association has had the usual turn-over of membership which affects all associations and has always had a small membership but each one has been active in its affairs.

OFFICERS

President .....Elizabeth J. Pratt, O.T.R.
Vice-President .....Elizabeth W. Whitaker, O.T.R.
Secretary .....Theodora Coates, O.T.R.
Treasurer .....Gertrude Sobolewski
Delegate .....Marjorie E. Roth, O.T.R.
Alternate Delegate.....Dorothy J. Wirt, O.T.R.

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Book Reviews

ADJUSTMENT TO PHYSICAL HANDICAP AND ILLNESS

Roger G. Barker *in collaboration with*
Beatrice A. Wright, Lee Myerson, Mollie R. Gonick
Published by
Social Science Research Council, N.Y.C.

Bulletin 55, Revised 1953 — 440 Pages

This is an involved study of the relation between physique and behavior. The authors studied the somatopsychological significance of individual differences, of crippling, of tuberculosis, of impaired hearing, impaired vision and acute illness.

The social significance of each involvement, the behavioral effects and studies made in each field are clearly defined.

The final chapter deals with the employment of the disabled in reference to the attitudes of employers, insurance rates for employment of the disabled, job analyses for placement, and the various opportunities for employment.

Of particular interest to occupational therapists is the impartial evaluation of activities. In tuberculosis cases, occupational therapy treatment was too diversional to be of value. A summary of occupational therapy in the study of acute illness stated "the chief weakness of the occupational therapy movement is its failure to develop an adequate rationale for its program. It has offered neither objective proof of its effectiveness, nor a theoretical basis for its procedures . . . On the other hand, recent developments in the understanding of play and projective techniques, of counseling and of personality and emotion would appear to provide excellent beginnings for an effective psychology of occupational therapy." This is very sound advice and exactly what our leaders have been propounding —there is need for extensive research in our field to establish workable hypotheses.

DEVELOPING THE CRIPPLED CHILD THROUGH PLAY

The National Society for Crippled Children and Adults, Inc.

1952 — 9 Pages

A list of toys used as aids in the work with cerebral palsied children. The toys were supplied by the American Toy Institute, research division of the Toy Manufacturers of U.S.A. and the study was made with the cooperation of the National Society for Crippled Children and Adults, Inc.

The toys are ones that may be available in local toy shops and the comments were made by the Cerebral Palsy Pre-School Center, Lenox Hill Hospital, New York (See AJOT, Vol. 6, 1952, page 189); Cerebral Palsy Center, Franklin County Society for Crippled Children, Columbus, Ohio; Meeting Street School for Crippled Children and Adults, Providence, Rhode Island.

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Occupational therapist wanted immediately. 173 bed county hospital. T.B. unit, custodial unit and general hospital. Program established. Attractive location,-mountain-seaside resort city. Apply at once, Director, County Hospital, Santa Cruz, California.

Occupational therapists and senior occupational therapists; Fairfield State Hospital, Newtown, Connecticut; well-equipped working units; modern buildings; good living facilities. For further information, apply to Superintendent.

Occupational therapists for large psychiatric hospital. Ideal opportunity for those interested in all inclusive program. Modern rooms, good food. Maintenance optional. Liberal periodic salary increases; holiday, vacation and sick leave benefits. Contact Director of Occupational Therapy, Osawatomie State Hopsital, Osawatomie, Kansas.

Wanted: Occupational therapist for work in cerebral palsy treatment center. Good salary. Good working conditions. Scholarship available for additional training in cerebral palsy. Program directed by diplomate of the American Board of Physical Medicine. Write Herman L. Rudolph, M.D., 400 North Fifth Street, Reading, Pennsylvania.

Occupational Therapists for large psychiatric hospital located in New England. Progressive, all-inclusive program for patients. Student affiliations with excellent educational program. Modern home, good food. Maintenance optional. Liberal retirement plan and illness policy. Paid vacations and holidays. Write to Director of Occupational Therapy, Norwich State Hospital, Norwich, Connecticut.

Occupational therapists (cerebral palsy) wanted in California. Excellent opportunities and working conditions. Salary $338 to $412 per month depending upon qualifications. For additional information and applications write to Kern County Personnel Dept., 3805 Chester Ave., Bakersfield, California.

Registered occupational therapists (4) for modern cerebral palsy out-patient treatment center. 35-hour week. Four weeks vacation with pay. Starting salary $3300 with annual increases. Uniforms and laundering supplied. Women preferred. Write C. H. Wiemer, Executive Director, United Cerebral Palsy Center, Roosevelt, Long Island, N.Y.

Position available: assistant occupational therapist for children's orthopedic treatment center. Salaries based on V.A. scale. Home for Crippled Children, 1426 Denniston Avenue, Pittsburgh 17, Pennsylvania.

Occupational therapist to direct a program in a free non-sectarian tuberculosis hospital. Challenging opportunity to work with a very cooperative group of patients. Excellent staff relationship. Beginning salary $3600.00. Write Fred Fragner, Director of Social Service and Rehabilitation, J.C.R.S. Hospital, Spivak, Colo.

Therapist for 200 bed children's hospital, salary $3300, month vacation with pay. Contact Barbara Brooks, O.T.R., Dir. of O.T. Dept., Children's Orthopedic Hospital, Seattle, Wash.

Director and assistant director, Occupational Therapy School, Australia. Term three to five years. Should have one year in teaching institution or training students. Begin duties 1954 or sooner. Fare paid both ways. Write Board of Management, Occupational Therapy School of Victoria, 72 Surrey Road, South Yarra, Melbourne, Australia.

Registered occupational therapist to head department in out-patient treatment center for cerebral palsied children. Forty hour week. Write Les Passees Treatment Center, 822 Court Avenue, Memphis, Tennessee.

Staff O.T.R. interested in functional work and daily activity training, 40 hour week, liberal vacation, holiday and sick leave benefits. Salary $3900-4740. The San Joaquin Rehabilitation Center, 548 South Wilson Way, Stockton, California.

Immediate opening: Registered occupational therapist for 350 bed tuberculosis hospital. Paid vacation, sick leave, retirement plan and uniform laundry. Staff occupational therapist positions available, also. Apply: State Tuberculosis Board, P.O. Box 286, Tallahassee, Florida.

Director of occupational therapy department wanted immediately for 330 bed private mental hospital. Salary starting at $450.00 per month, but commensurate with experience. Apply: Medical Director, The Seton Institute, Baltimore 15, Maryland.

Immediate openings for occupational therapists; 330 bed private mental hospital. Salary, paid vacation, etc., according to training and experience. Apply: Medical Director, The Seton Institute, Baltimore 15, Maryland.

Registered occupational therapist for psychiatric hospital. Start November, salary $309-379, maintenance available at $40. Write for particulars: Oregon State Hospital, Salem, Oregon.

Immediate opening: Excellent opportunity for registered therapist. Progressive department with broad and varied activities including new children's program. Paid vacation, holidays, sick leave. Salary $3432-$4200, liberal increase first year, maintenance optional. Write to Personnel Officer, Caro State Hospital for Epileptics, Caro, Michigan.

O.T.R. for newly opened psychiatric unit of general hospital, affiliated with medical school in Eastern city. Active treatment, research and training program. Desire therapist with special interest in recreational activities. Salary commensurate with experience and qualifications. Write Box 0-6, AJOT.

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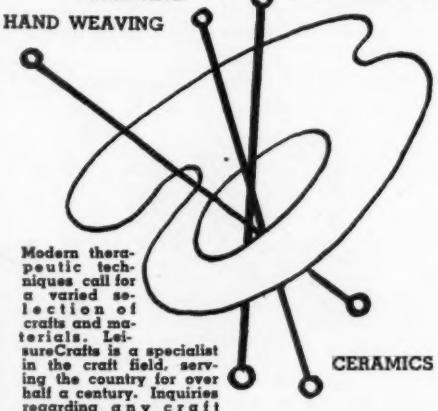

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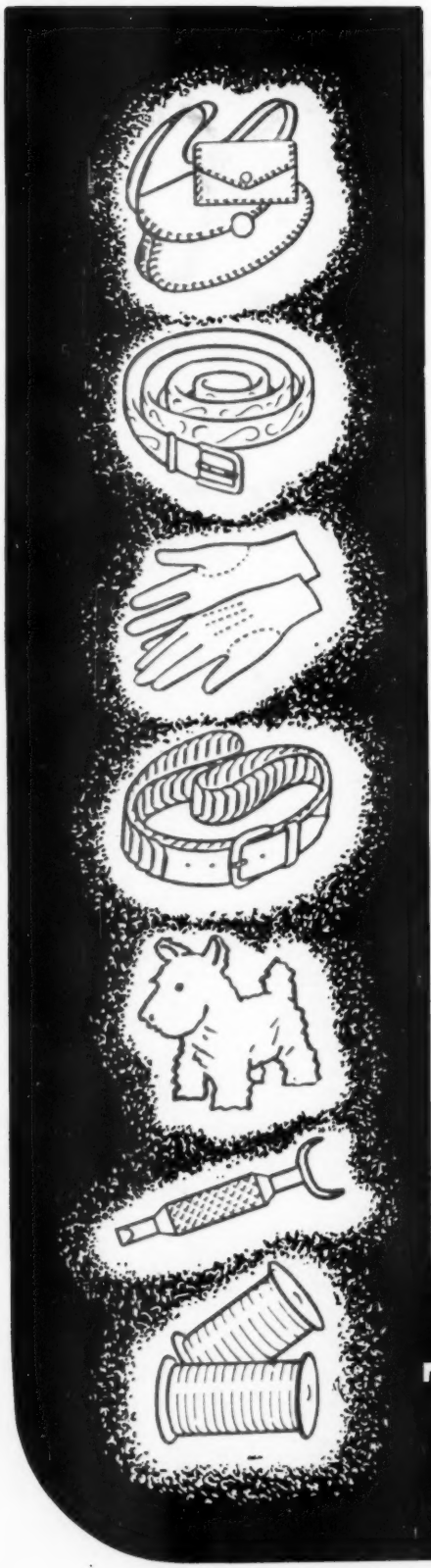

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